University of Alberta

From Theory to Praxis: Empowering Women's Health

By

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A Thesis submitted to the
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requirements for the degree of Master of Arts

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Date: 20 August 2001

From the perspective of cyborgs, freed of the need to ground politics in 'our' privileged position of the oppression that incorporates all other domination, the innocence of the merely violated, the ground of those closer to nature, we can see powerful possibilities.

- Donna Haraway

DEDICATION

In Loving Memory of My Father
Gerald Carson McNutt

ABSTRACT

From Theory to Praxis:
Women's Empowerment

This thesis examines how the synergistic affects of hyper-technology, neoliberalism and neoconservatism are acting to impair women's full health potential and associated empowerment. I argue that it is feminist theory that informs feminist praxis, which in turn initiates actions aimed at revolutionary change to the current political, social, and economic edifices. Therefore, the significance of feminist theories to explain and offer viable alternatives to current political practices and the contemporary hegemonic paradigm characteristic of the Canadian state is paramount to the agenda of the women's movement. I contend that the practicable application of feminist theory to women-centered activism is vital in achieving women's empowerment and illustrate my theoretical conjectures with various practical examples focused on women's health. While I consider feminist theory to be a significant dimension of the women's movement, I argue that the theories are only as potent as the activism they are capable of generating.

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And Patrick, whose intelligence, love and sustained confidence provided me with a wealth of inspiration and the strength to continue regardless of circumstances.

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LIST OF ABBREVIATIONS

AFN	Assembly of First Nations
AI	artificial insemination
CHA	Canadian Health Act
CHST	Canadian Health and Social Transfer
DIAND	Department of Indian Affairs and Northern Development
FFQ	Fédération des femmes du Québec
FNIHB	First Nations and Inuit Health Branch
IVF	in vitro fertilization
NAC	National Action Committee on the Status of Women
NRTs	New Reproductive Technologies
MSB	Medical Services Branch
NWAC	The Native Women's Association
RCAP	Royal Commission on Aboriginal People
RCHC	Royal Commission on the Future of Health Care (2001)
RCSW	Royal Commission on the Status of Women
SCHC	Saskatchewan Commission on Health Care

Introduction

From Theory to Praxis: A Recipe for Women's Empowerment

It does not matter much to the figure of the still gestating, feminist, antiracist, mutated modest witness whether freedom, justice, and knowledge are branded as modernist or not; that has never been our issue. We have never been modern. Rather, freedom, justice, and knowledge are – in bell hook's terms - about yearning, not about putative Enlightenment foundations. Keep your eye on the prize. Keep our eyes on the prize.

– *Donna Haraway* [1]

Medicare is a defining quality of Canadian society, it is Canada's most cherished social program, and a majority of Canadians believe it is an inherent aspect of their citizenship rights. The current propensities of both the federal and provincial governments, however, have been to downsize, privatize, and fundamentally erode the Canadian health care system. Their attempts to slaughter the sacred cow of Canadian social policy have not, as of yet, been successful, nevertheless, the system has suffered extensive injuries. The erosion of the Canadian health care system has been advanced by a governing orthodoxy that claims that the traditional Medicare system is not amenable to the recently minted neoliberal state and, as such, must be ameliorated through a process of comprehensive restructuring. Previous not-for-profit methods of health care delivery are being incrementally replaced by profit-driven health care models, which high-profile state actors such as Paul Martin and Allan Rock rationalize as a necessary measure for improving the efficiency of the health care system. Contemporary political and economic impulses, symptomatic of the new governing philosophy of neoliberalism, regard universal health care as a luxury the public purse can no longer maintain. The state's cure for the ailing health care system has been to cut costs, which has precipitated the federal government's retraction of funding to the

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[1] Donna Haraway, *Modest_Witness@Second_Millennium. FemaleMan©Meets OncoMouse™: Feminism and Technoscience* (New York: Routledge, 1997), 191.

provinces, severely diluting their ability to regulate the delivery of health care services as outlined in the Canadian Health Act. The provincial responses have varied, with some provinces aggressively delisting services to curb costs and other provinces introducing legislation that allows for the privatization of particular health care services.

The reaction to the breakdown of the health care system from the Left has been deficient, with either a nostalgic rejoinder calling for a return to the 'good old days' or a fatalistic reaction suggesting that the predatory grip of capitalism and the momentum of the New Right are beyond contestation. These types of responses are ineffective and exacerbate an already critical situation, providing little in the way of a feasible alternative. The state's fiscal capacity, policy agendas and political goals are changing rapidly and radically, and the Left will need to keep pace with the trajectory of Canadian social policy if they are going to contest this discursive terrain. The agendas, ideological frameworks, goals and outcomes of Canada's social policy have been altered so frequently and dramatically since World War Two, it has become almost impossible to account for all of the complex dynamics at work in the various paradigm shifts. What can be observed definitively is that the welfare state model of the sixties and seventies is no longer viable for the new millennium. Forces of globalization, fiscal restraints, neoliberal governing philosophies, the dilution of organized labour, and the devaluation of social movements as 'special interests,' have all coalesced to establish a new state form that deviates significantly from the post-war welfare state. Women, who never enjoyed equality during the welfare state regime, are now being confronted with a far more insidious state form that threatens to erode gains already acquired and create new evils.

Public policy, health care, restructuring, downsizing, neoliberalism, and neoconservatism all share two common dominators. First, they all affect women differently than men and this differential impact is furthered complicated by factors of ethnicity, race, sexual orientation, age, class, ability and language. Second, the decision-making bodies that determine how these forces will be written into state structures fail to address the manner in which the reconfiguration of the Canadian state is impairing women's ability to participate in those processes, structures and policies that dictate the outcome of their lives, health and equality. Women in the Canadian state have never

enjoyed the same privileges as men. The policy process has always been premised on an androcentric model, which perpetuates a variety of oppressive and inequitable programs and services. With the government and other economic actors sounding a tocsin about the health care crisis in Canada, health boards, health services and hospitals all scramble to reduce expenditures and phase out programs. Operating in tandem with fiscal restraints are the new relationships imposed by policy-makers concerning the government's interaction and responsibility to its citizens. Off in the wings stands the women's movement, racked with internal dissent, financially strapped and emotionally drained. In a decade when the forces of patriarchy, advanced capitalism and technology are bearing down on the Canadian state like a tidal wave, large national women's organizations, such as the National Action Committee on the Status of Women (NAC), recoil into the margins following a barrage of delegitimization by the government, the media, and to some degree, the general public. The women's movement is being systematically silenced and undermined in its ability to act on behalf of women's realties and experiences, and as such, women's avenues for activism have narrowed dramatically.

Despite the various obstacles faced by the women's movement and other feminist advocates, there is still an opportunity to contest the current state configuration and demand a more participatory polity that includes the voices of women and marginalized others. This will however require a concerted effort on the part of both feminist academics and grassroots activists. The challenge for contemporary Canadian feminism will be to address the myriad of identities that the women's movement represents, in addition to establishing new forms of contestation that challenge the current hegemonic paradigm. It is my contention that we must enhance the marriage of grassroots activism with feminist political and social theory, which will strengthen the ability of the women's movement to act as a vehicle of change.

The intellectual panorama of feminism encompasses a diverse body of work that outlines various political agendas and is ground in assorted theoretical frameworks. Traditionally, feminist theory has been determined by the deployment of particular discourses for specific political purposes. In general, feminist theory is the ground upon which the women's movement marches forward, and as such does not simply act as a

descriptive mechanism delineating analytic, abstract concepts; but rather provides feminists with the political tools necessary to delegitimize the traditional patriarchal order. The unification of theory and action has been the primary driving force behind the majority of the women's movement's successes. It is feminist theory that informs feminist praxis, which in turn initiates actions aimed at revolutionary changes to the current political, social, and economic edifices. Therefore, the significance of feminist theories to explain and offer viable alternatives to current political practices and the contemporary hegemonic paradigm characteristic of the Canadian state is paramount to the agenda of the women's movement.

The women's movement has been the most dynamic and transformative social movement of the modern industrial era. Unfortunately, the partnership between feminist scholars in the academy and grassroots activists on the frontlines has suffered in the past several decades, mired in identity politics, rendered extraneous by globalization and undermined by speculations of a post-feminist era. Nonetheless, a brief survey of the contemporary terrain of feminist politics illustrates the manner in which many of the divisive obstacles that plagued the movement have been overcome in the past several years. The manner in which feminist theory has engaged itself in a perpetual process of reframing problems and prescribing various remedies has led to a growing awareness that women, as a category, are multidimensional and that there exist important differences among them. In addition, feminist scholarship, which is as diverse as it is complex, continues to interrogate women's contradictory relation to the state. On the one hand, women have looked to the government for protection against male violence and economic injustice, and on the other, women have implicated the state's role in that violence and injustice. In the past, feminist theories have sought to clarify the relationship between state power and gender relations in a variety of fashions. While some theorists contend that patriarchy is the underlying cause of women's subordinate position, others give priority to improving the status of women in existing political, social, and economic institutions. This sundry of feminist theories has provided both academics and activists with a wealth of knowledge, an expanded repertoire of theoretical tools, and various other insights into patriarchal structures and phallocentric discourses.

The various articulations of feminist praxis encompass a diverse body of work, however, the goals are analogous – to locate a formula that empowers women. Women's full health potential is currently being impaired by the neoliberal configuration of the state, a myriad of neoconservative ideas and the exponential growth of technological developments. In order to arrest these insidious forces the women's movement and feminist scholars must develop a new feminist praxis. The challenge, as I see it, is to provide the women's movement with practical theories which inform feminist praxis and illustrate that patriarchy continues to manifest in the systematic forfeit of individual choices, political power, economic freedom, and intellectual recognition which is currently experienced by all women in varying degrees. In addition, feminist scholars must address the manner in which neoliberalism has promoted the predatory grip of capitalism to affect every aspect of Canadian's social citizenship. Further, feminist academics must develop theories that are inclusive without speaking 'for' marginalized groups. While the prerequisites for a feminist theory that informs praxis are numerous, the urgency of a women's movement's agenda that addresses the various forces of neoliberalism is acute. Practical applications of feminist theory include a vast array of activism, all of which should be considered transformative. Praxis is thus both a political ideology and a tool for policy initiatives that the women's movement and advocates of women's full health potential must ground their activism in for the creation and sustainment of women's empowerment. A feminist praxis ascribes the reshaping of many basic cultural beliefs, patterns of capitalist consumption and health care methodologies. In essence, feminist praxis draws a map detailing the road to women's empowerment, charting out those feminist theories that best signal the major road blocks on the journey to a woman's full health potential, plotting out necessary junctures of change, and providing clarity and direction towards the final destination of women's empowerment and its relation to health. Working in solidarity, feminists must identify the necessary theoretical tools and avenues of activism that will serve to empower women and facilitate the obtainment of their full health potential.

In this project I contend that the practical application of feminist theory to women-centered activism is vital in achieving women's empowerment. I define praxis

as theoretically informed political action directed at realizing the objectives of a movement. As such, I adhere closely to the definition put forth by Mary O'Brien, who suggests that praxis is the "unification of theory and practice as a method of changing the world."[2] I consider feminist praxis to be an approach used to critique the dominant political and cultural paradigms. This perspective favors an equitable relationship between the complex communities of Canadian citizens and seeks to protect individuals from impositional state claims by invoking action that respects our diverse and multiple identities. If an effective feminist praxis is to be generated, it must be demonstrated theoretically, seeking to interpret and possibly explain the manner in which the state functions to impair the citizenship status of women and marginalized others. Moreover, it must generate fluidity to accommodate the various types of activism and the numerous problems activists are confronted with. The cerebral fitness of the theories will be tested continually by frontline lobbyists and thus must display a great deal of political flexibility without usurping the core tenets of the feminist doctrine. Feminist praxis is thus a synthesis of theory and practice, which seeks to locate the source of state domination theoretically and transform it practically.

Substantively, then, this thesis is a critical inquiry into policy associated with women's health in the Canadian state. I explore the synergistic affects of neoliberalism, neoconservatism and hyper-technology. These topics are approached from a critical feminist perspective, employing a variety of theoretical tools, which provide the opportunity to explore several different modes of 'theorizing' about women's health. Further, by considering some of the more central conceptual and practical challenges to women's health, I argue that the potency of the women's movement is predicated on its ability to define a practical feminist praxis. Two primary questions guide this research. First, how is the new state configuration impairing or improving women's health status? Second, what key theoretical tenets will provide the necessary impetus for women's empowerment and its relationship to health? In order to address these questions this thesis will be divided into four primary sections.

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[2] Mary O'Brien, "Feminist Praxis" in *Feminism: From Pressure to Politics,* Angela R. Miles and Geraldine Finn, eds. (Montreal: Black Rose Books, 1989), 336.

The first chapter examines the manner in which new and advanced forms of technology are serving to impair women's full health potential and impede their empowerment. I begin by exploring feminist critiques of science, technology and the biomedical model and then move on to discuss the manner in which technology, in the context of health care, is articulated through the biomedical model. Next, I investigate the affinity between capitalism and technology by employing a typology developed by Elizabeth Grosz. To demonstrate the manner in which my theoretical conjectures concerning hyper-technology can be translated into practical applications and tools of activism for the women's movement, I discuss new reproductive technologies and their impact on women's health. The primary objective in the first chapter is to illustrate how important discussions of technology are in understanding neo-patriarchy and recognizing the close affinity between technology, neoliberalism and neoconservatism.

The second chapter discusses women's citizenship and the contemporary configuration of the Canadian state. To begin I explore feminist conceptualizations of citizenship and define a citizenship praxis that serves as a springboard for the ensuing discussions. Subsequently, I trace the historical evolution of Canadian state forms and the citizenship regimes associated with each. Two main eras will be explored: the post-war Keynesian welfare model and the current project of neoliberalism. Following this I examine how neoliberal and neoconservative ideas are eroding many of the precious gains garnered by the women's movement and creating new barriers for women's participation in the future. I use the women's movement's agenda for health as an illustration of the theoretical conjectures I present. The primary objective in this second chapter is to illustrate the manner in which neoliberalism and neoconservatism are acting in concert to impair women's full health potential and undermine women's empowerment.

The third chapter concentrates on public policy concerning women's health. In this chapter I examine the importance of employing a gendered lens to women's health care and developing a 'women friendly' blueprint for policy design. Further, this portion of the thesis delineates several of the state's commitments to a gendered analysis and highlights the government's failure to bring to fruition fundamental changes to the policy-making process. I argue that gender is a key health determinant

and the failure to recognize women's situated location within the Canadian polity has resulted in the production of health care policy that fails to appreciate the full spectrum of obstacles that impair women's full health potential. To illustrate the manner in which policy entrepreneurs' failure to incorporate gender into the creation of health care policy impacts women's full health potential, I consider the health status of Aboriginal women, who are often marginalized to the peripheries of health care design and implementation.

The fourth chapter of this project examines the current Canadian health care crisis and argues that the recently established national health care commission affords feminist scholars and the women's movement with the opportunity to contest those structures, policies and assumptions that impair women full health potential. To begin, I discuss the health care crisis and its attendant discourses of efficiency and effectiveness. Next, I examine the recently tabled Saskatchewan Commission on Health and survey the processes emanating from the provincial report to extrapolate strategies that may be employed by the women's movement during the federal commission. This section of the thesis is not a detailed exposition of the past involvement of the women's movement in the politics of health, rather it outlines an agenda for the future and highlights some of the key considerations and priorities the movement must address. Following this I examine several of the strategies used by the women's movement to address the affects of neoliberalism, hyper-technology and neoconservatism. Finally, I outline the women's movement's contemporary agenda for addressing women's health and its relationship to empowerment.

Prior to beginning this project it is necessary to identify a tangible goal. As such this project will briefly discuss women's empowerment and its relationship to health. In the area of women's health, there is a plethora of scholarly material, focusing on a myriad of topics and issues; however, when the core concepts are fleshed out and analyzed there is an overwhelming consensus that women's empowerment in relation to health is the central commitment of these academic endeavors. Similarly, the women's health movement and grassroots activists are primarily concerned with equipping policy architects, the medical establishment and women with the necessary tools for enabling women to enjoy their full health potential. Empowerment is thus a common denominator between the academy and the grassroots, as it provides direction towards

an achievable goal, in addition to promoting change at an individual level, at an organizational level and within the community. For the purposes of this thesis I adopt a definition of empowerment put forth by Nina Wallerstien and Edward Bernstein who suggest that "[empowerment is] a social action process that promotes the participation of people, organizations, and communities in gaining control over their lives in their community and larger society. With this perspective, empowerment is not characterized as achieving power to dominate others, but rather power to act with others to effect change."[3] If we define empowerment as the eventual goal for women's health, then the development of a feminist praxis that would guide this transformation becomes paramount. Feminist praxis will thus direct the social and political agenda of the women's movement through a process of "listening, dialogue, discussion [and] self-reflection to critical thought to action and back."[4] Each step in this process is a prerequisite for women's empowerment and its relationship to their health; however, this project will focus specifically on the critical thought and action portions of this process. Through this focus, I hope to capture what I believe to be the principal challenge facing women's obtainment of their full health potential. With this in mind I would like to offer several definitions.

For the purposes of this project, neoliberalism will be defined as "an ideology that advocates an economic arena free of government regulation and restriction, including labour and environmental legislation, and certainly free of government action via public ownership. It advocates a retreat from the welfare state's publicly funded commitments to equality and social justice. It views citizenship as consumption and economic production."[5] Neoconservatism should be understood as both an "ethical and political agenda, a return to a social or moral traditionalism" in which "social relationships must be disciplined and predicted" with "social and political constraints on

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[3] Quoted in Jane Stein, *Empowerment & Women's Health: Theory, Methods and Practice* (London: Zed Books, 1997), 7.

[4] Ibid., 60.

[5] Joyce Green, "Resistance is Possible" in *Canadian Women's Studies,* vol.16, no.33 (Summer 1996), 112.

individual freedom."[6] Globalization will refer to "an economic process in which barriers among nations are reduced and economic activity is organized on a global" scale, which "tends to provoke economic restructuring."[7] Health will encompass the physical, emotional, mental and spiritual dimensions of an individual's life situation, with full health potential signaling a wholesome balance among these four aspects of health promoting an overall state of well-being.

Throughout this thesis I will be using women's health as a practical example of the theoretical questions I examine. I believe that health, and more specifically women's health, serves as a compelling illustration of women's differential relationship to the state, in addition to highlighting the manner in which women tend to be the main beneficiaries of social programs and are thus most affected by the new fiscal restraints imposed by the neoliberal state. My justification for using health care as a practical example is three-fold. My first rationalization comes from the fact that women use the health care system more then men.[8] My second reason is that the majority of health care workers are women, including nurses, maintenances staff, homecare workers, dietitians and technicians. The third reason I chose health care is associated with the agenda of the women's movement. During the campaign of the World March of Women, the Canadian March Committee presented the federal government with thirteen demands aimed at eradicating poverty and ending violence against women. The very first demand of this feminist dozen was a call for the federal government to restore funding to the health care system and enforce the regulations of the Canadian Health Act.[9] Women's health serves as a powerful example of the new social contract emerging from the Canadian state as it reveals the fashion in which the new governing philosophy of neoliberalism coalesces with neoconservative ideas and technological

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[6] Linda Trimble, *Women, Public Policy and the New Right*, public lecture of the Saskatchewan Institute of Public Policy at the University of Regina (October 15, 1999).

[7] Jill Vickers, *Reinventing Political Science: A Feminist Approach* (Halifax: Fernwood Publishing, 1997), 194.

[8] Women's disproportionate use of the health care system arises from their reproductive functions, their responsibility for family members and the fact that they outlive men.

[9] Canadian Women's March Committee, "It's Time For Change!" in *Canadian Women's Studies*, vol.20, no.3 (Fall 2000), 23.

development to fundamentally impair women's ability to fully participate in Canadian society. Women's inequality has been exposed, theorized and contested by feminist scholars and activists alike; however, each and every one of these feminist struggles is futile if women are unable to maintain their health. The path to women's empowerment is onerous, with roadblocks and potholes abounding, each step however brings the movement one step closer to the final destination. The current assault on health care is exemplary of the synergistic forces of neoliberalism, neoconservatism and hyper-technology and their affects on women's status in contemporary Canadian society and as the World March of Women's banner slogan suggests, 'It's Time For Change.'

Chapter One

Entering the Corridors of Hyper-Technology

He could fake the tests, report me for cancer,
for infertility, have me shipped off to the Colonies with the Unwomen.
None of this has been said, but the knowledge of his power hangs nevertheless
in the air as he pats my thigh, withdraws himself behind the hanging sheet.

- Margaret Atwood [10]

Introduction

Bold headlines announced the birth of the world's first test-tube baby, born in Britain on 25 July 1978.[11] On February 24, 1997, Scotsman Ian Wilmouth cloned a sheep named Dolly; critics quickly nicknamed him Dr. Frankenstein.[12] More recently in Texas, scientists have discovered a substance that halts the aging process - the "elixir of youth."[13] The human condition in the early 21st century is mapped through scientific research such as The Human Genome Project, genetically modified food, space travel to Mars, Artificial Intelligence, virtual reality and so forth. In the current industrial era marked by advanced capitalism and growing inequality, these scientific innovations are the quintessential emblems of the human species' progress. To the scientific outsider these signposts of advancements are presented abstractly and defined in inaccessible language, making it difficult to separate reality from speculation and science from politics. While corporate interests promise disease free crops and medical miracles, critics warn that this form of technology is the handmaiden of capital in the post-industrial era. Jonathon King and Doreen Srabinsky contend that human society is rapidly entering "the first stages of the technological revolution,"[14] a transformation that

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[10] Margaret Atwood, *The Handmaid's Tale* (Toronto: McClelland and Stewart, 1985), 71.

[11] E. Peter Volpe, *Test-Tube Conception: A Blend of Love and Science* (United States: Mercer University Press, 1987), 1.

[12] Bruce Wallace, "The Dolly Debate" in *Maclean's*, vol.110, no.10 (March 10, 1997), 51-52.

[13] Alexander Kutaryov, "Be Fruitful and Multiply: The Frankenstein Problem" in *New Times: Monthly Digest of Russian Weekly Novoye Vremya* (March 1998), 52.

is clearly evidenced by the exponential growth in computer and communication technology, genetically engineered crops, manipulation of human, plant and animal genomes, and dramatic advances in biomedical research.[15]

Although neoliberalism, globalization, and neoconservatism all feature predominately in the current configuration of the Canadian federation, there is another aspect of Canadian society, which is often ignored in discussions of the state. I will refer to this phenomenon as hyper-technology. Hyper-technology in an advanced industrial nation such as Canada is ubiquitous, developed as an exclusionary mechanism of patriarchal control. Hyper-technology is characterized by technical determinism, which views "rule by expert and [human] displacement by machine as inevitable."[16] Progress in Western culture has always been measured in terms of technological advancement and scientific innovation. In essence, hyper-technology engulfs the human experience, leaving individuals both fascinated and perplexed. Every aspect of our lives is influenced by technology and the trajectory of hyper-technology has been unyieldingly rapid, bombarding society with email, cell phones, pagers, e-government, automated state services, surveillance policing and so forth. Hyper-technology is thus the continual development, improvement, creation and dissemination of machines, technology and knowledge that are controlled and manipulated by an elite few.

This section of the project will explore hyper-technology and the impact it has on women, and by extension their health. To begin, I discuss several feminist critiques of technoscience and then synthesize these various theoretical positions to create a framework that reveals the complex and myriad ways that hyper-technology shapes women's lives. Specifically, I considered how scientific knowledge is constructed and used as a tool of domination and control. Next I explore the use of the biomedical model in modern conceptualizations of health and health care. To illustrate my

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[14] Jonathon King and Doreen Srabinsky, "Biotechnology Under Globalisation: The Corporate Expropriation of Plant, Animal and Microbial Species" in *Race and Class*, vol.40, no.2/3 (1998-1999), 73.

[15] Eric S. Grace, *Biotechnology Unzipped: Promises and Realities* (Toronto: Trifolium Books Inc., 1997), 232.

[16] Margaret Lowe Benston, "A New Technology But the Same Old Story" in *Canadian Women Studies*, vol.13, no.2 (Winter 1993), 68.

theoretical conjectures with a practical example I will examine the impact and ramifications of new reproductive technologies (NRTs) on women's health and life situations. My primary goal in this chapter is to identify how hyper-technology influences our understanding of health and serves to disempower those individuals that have been alienated from the scientific paradigm.

Theory: Feminism vs. The Man of Science

Evelyn Fox Keller defines science as "a name we give to a set of practices and a body of knowledge delineated by a community."[17] The ambiguity of Fox's definition is telling; as it highlights the manner in which science is what those individuals engaged in scientific research say it is. Those of us standing outside the scientific paradigm are expected to display blind faith in the objectivity and neutrality of those that produce and disseminate this form of knowledge. According to many feminists this conceptualization of science behaves as a bastion in which profoundly sexist, racist, and homophobic assumptions are fabricated and maintained.[18] Although the discourses of science manufacture particular definitions concerning gender, women are generally disenfranchised from the production of scientific knowledge. Science is by no means a democratic project, but is rather an elitist enterprise in which experts purport to accumulate 'truths' through the use of particular methodologies and specific procedures. Jean Barr and Lynda Birke argue that science is the "master narrative" of contemporary culture, dictating how we understand the natural world, society and ourselves.[19] Fundamental to interpreting women's relationship with science is an understanding of how women have been constructed as closer to nature. In order to build a theoretical framework that captures the complex dynamics serving to impair

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[17] Evelyn Fox Keller, "Gender and Science: An Update" in *Women, Science, and Technology*, Mary Wyer, Mary Barbercheck, Donna Giesman, Hatice Örün Öztürk, and Marta Wayne, eds. (New York: Routledge, 2001), 133.

[18] See for instance: Sandra Harding, "Feminism, Science, and the Anti-Enlightenment Critiques" in *Feminism/Postmodernism*, Linda J. Nicholson, ed. (New York: Routledge, 1990), 83-106.

[19] Jean Barr and Lynde Birke, *Common Science? Women, Science, and Knowledge* (Bloomington and Indianapolis: Indiana University Press, 1998), 9.

women's full health potential and illustrate the synergistic affect of hyper-technology, neoliberalism and neoconservatism it will be necessary to explore a variety of insights from several schools of feminist thought. To this end, I will begin my analysis with an exploration of ecofeminism, a doctrine that provides a clear delineation of the methodology applied by the man of science to explain women as closer to nature, and by extension as a resource to be conquered and exploited.

Ecofeminists focus on the correlation between the domination and oppression of women and the domination and exploitation of the earth, working in the direction of their simultaneous emancipation.[20] The theory is unsympathetic to international capitalism and consumer self-interest, arguing for nothing less then a complete reconfiguration of the political, economic, and cultural institutions characteristic of the new global village. Their ideology gravitates around the notion that equality for women is not impossible without the emancipation of nature and that the emancipation of nature is unobtainable without equality for women. In this sense they argue that this matrix of domination must be dismantled, if the relationship between men and women, and between humans and the earth is to reach a sustainable and equitable balance.

The logic of domination, according to Karen Warren, is the foundation upon which patriarchy, capitalism, and Judeo-Christianity are established. In this portion of the thesis, the logic of domination will be deconstructed to reveal the intellectual presumptions embedded within both political and social conceptual frameworks. In this sense the environmental movement and the feminist movement are inextricably intertwined, both seeking to transform "that worldview which underlies the domination and replacing it with an alternative value system."[21] Ecofeminists define the logic of domination as an oppressive patriarchal framework, which serves to exploit the earth and subordinate women. This form of logic is manufactured through the establishment of conceptual frameworks that dictate an individual's world-view and self-perception.

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[20] The majority of ecofeminists have acknowledged that the subordination of females by males was historically prior to the exploitation of the earth by human beings. See: Karen Warren, "Wrongs of Passage" in *Ecological Feminism*, Karen J. Warren, ed. (New York: Routledge, 1994), 30.

[21] Rosemary Radford Ruether, *New Woman New Earth: Sexist Ideologies and Human Liberation* (New York: Harper & Row Publishers, 1975), 204.

Ecofeminists identify three specific types of conceptual frameworks: patriarchal, value-hierarchical thinking, and the logic of domination.

A patriarchal conceptual framework is predicated on the dominant world-view of androcentrism and is most notably identified through the use of language. Ecofeminists argue that femininity has always been paralleled with nature, as is manifest in the linguistics of contemporary discourses, for instance, the 'virgin forest' or the 'rape of the earth.' Further, once nature has been designated as female, it is sexualized: the fertile soil of the earth is tilled; Mother Nature is conquered, mastered, raped, and the man of science penetrates her womb.[22] These androcentric global assumptions explicitly construct men as superior and therefore, anything that has traditionally been identified as male is granted higher status.[23] Inherent in these patriarchal ideologies, values, attitudes and assumptions is the notion that anything personified, as female, deserves inferior status and may be subjugated. Ecofeminists advance the postulate that the Master/servant relationship takes traditional male-identified beliefs, values, knowledge and so on, as universal standards. Ecofeminism advocates a deconstruction of the categories 'feminine' and 'masculine' and highlights the practices of racism, classism, sexism and ecological destruction inherent within this network of patriarchal oppression.[24]

In contrast, value-hierarchical thinking, which is essentially hierarchical dualism, situates men at the pinnacle of the social and political hierarchy while women and nature are positioned below.[25] This thought process stems from the reproduction of the classic political and philosophical metaphors, which are predicated on ordered

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[22] Karen Warren, "Ecological Feminist Philosophies: An Overview of the Issues" in *Ecological Feminist Philosophies* (Indianapolis: Indiana University Press, 1996), xv.

[23] This systematic construction of nature as feminine became popular during the Enlightenment period. Although feminizing nature began in the pre-Enlightenment era it was not the dominant practice. See: Carolyn Merchant, *The Death of Nature: Women, Ecology, and the Scientific Revolution* (San Francisco: Harper and Row, 1980), generally.

[24] Val Plumwood, "The Ecopolitics Debate and the Politics of Nature" in *Ecological Feminism,* Karen J. Warren, ed. (New York: Routledge, 1994), 72-74.

[25] Karen Warren, "Feminism and Ecology: Making Connections" in *Environmental Ethics,* vol.9, no.1 (Spring 1987), 6.

binary oppositions. These dialectics are a symbolic system that couples two entities together on a "universal battlefield" to produce an outcome where the entity on the left is granted higher status, privilege, and authority.[26] For instance the binary constructions of Man/women, Culture/nature, Master/slave, Mind/body have all historically valued the left side of the set over the right side.[27] These normative dualisms create hierarchies that result in humans perceiving themselves as stewards of the earth, instead of living harmoniously with nature and understanding human dependency on the natural environment.[28]

Warren juxtaposes patriarchal conceptual frameworks and value dualisms to explain what she suggests are the eventual outcome of these two modes of thought: the logic of domination. She uses an axiomatic derivation to illustrate how the logic of domination is disseminated, manufacturing androcentric value-hierarchical thinking. She links these oppressive binary structures to other Western cultural practices to expose the logic of domination's ability to establish and advance the assumption that superior groups (men, humans) exist in society and that they may logically dominate other inferior groups (women, nature).[29] Finally, Warren argues that this logic sanctions the twin domination of women and nature and expels any ethical complications by alleging that women and nature are somehow morally and intellectually inferior to men.[30] These conceptual frameworks act as props that keep the

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[26] Ariel Salleh, *Ecofeminism as Politics: Nature, Marx and the Postmodern* (New York: Zed Books Ltd., 1997), 36-38.

[27] Some ecofeminist scholars believe the devaluation of the right hand side is further exacerbated when it is a non-human entity, which explains such events as the mass starvation of African elephants or the high occurrence of the great predator cats on the endangered species lists. These theories are premised on the notion that human colonization demands vast territories that continually expand their borders which impedes on the normal migration of large land animals or on the hunting territories of large the large predator cats and canids. See: Greta Gaard, "Ecofeminism and Wilderness" in *Environmental Ethics*, vol.19, no.1 (Spring 1997), 5-24; Linda Hogan, Deena Metzger, and Brenda Peterson, eds., Intimate *Nature: The Bond Between Women and Animals* (New York: Fawcett Books, 1998); Ronnie Zoe Hawkins, "Ecofeminism and Nonhumans: Continuity, Difference, Dualism, and Domination" in *Hypatia*, vol.13, no.1 (Winter 1998), 158-197.

[28] Elizabeth Dodson-Gray, *Green Paradise Lost* (Massachusetts: Roundtable Press, 1979), 20.

[29] Karen J. Warren, "The Power and the Promise of Ecological Feminism" in *Ecological Feminist Philosophies*, Karen J. Warren, ed. (Indianapolis: Indiana University Press, 1996), 37 note 4.

[30] Ibid., 23.

historical subordination of women and nature static. The implications of this are such that androcentrism, with its position at the pinnacle of the hierarchy, and by corollary, its access to power and resources, is rendered completely invisible. Therefore, one of the primary goals of ecofeminism is to discern this logic and recognize "the connections between their historical subordination and prevailing social and environmental injustices" which requires an articulation of their claims at "both the theoretical and political levels."[31]

Women's status as closer to nature has long been advanced through scientific theorems concerning female biology. For centuries biological differences between women and men have been viewed a natural and inevitable, serving to reinforce and maintain particular sex roles. The affects of biology on women's social status are not however rooted in pure scientific inquiry, but instead appeal to social, economic and political considerations. As Donna Haraway asserts, "biological theory is simultaneously and necessarily political theory" as it is always "a statement about power."[32] The chief example is of course women's reproductive functions determining their roles as mother, nurturer and caregiver, which are used to justify the devaluation of the private sphere and women's unpaid domestic labour. Feminists of all stripes have rejected the core tenets of biological determinism, which argues that women are "genetically predisposed towards nurturing behavior, while men are inclined towards adventures and fights."[33] Instead, feminist scholars have argued that while women do display certain biological endowments, a majority of feminine characteristics are acquired culturally. There is a plethora of feminist arguments remit of biology, focusing specifically on social forces and the impact these have on gender.[34] In a discussion of women's health however, there is a need to differentiate bodies as

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[31] Katherine Pettus, "Ecofeminist Citizenship" in *Hypatia*, vol.12, no.4 (Fall 1997), 150.

[32] Donna Haraway, *Primate Visions: Gender, Race, and Nature in the World of Modern Science* (New York: Routledge, 1989), 100.

[33] Lynde Birke, "Bodies and Biology" in *Feminist Theory and The Body,* Janet Price and Margaret Shilddrick, eds. (New York: Routledge, 1999), 42.

[34] For example see: Judith Butler, *Bodies That Matter: On The Discursive Limits of "Sex"* (New York: Routledge, 1993), generally.

biological organisms and biological bodies mediated through culture. Breast cancer for example, may be used to adduce the argument that women's physiology is susceptible to a specific stain of cancer, establishing 'woman' as a specific category of organism that is vulnerable to a gendered disease. As such the interior space of women's bodies must be viewed through a biological lens in which a female physiology must maintain homoeostasis as "health is a matter of maintenance, or keeping things constant while disease represents perturbation."[35] Understood in this context, women as biological organisms are "self-actualizing agents" that possess an ability to transform, repair, maintain and reconstitute themselves – the biological body ascribes women agency.[36] In contrast, women's outer bodies are subjected to the constant scrutiny of the male eye and cultural inscriptions of beauty, generated by consumerism and maintained by women's own engagement in the system. The difference between bodies as biological organisms and biological bodies has increasingly been erased through the use of hyper-technology's ability to accommodate arguments of the malleable female body through the intervention and control of the body's biological functions.

To illustrate the theoretical suggestions I have just proposed, I will explore how women's biological bodies are both a site of resistance and a location of intense social control. For centuries women have been primarily valued for their ornamental qualities and their reproductive function. In western culture good looks, thinness and youth are considered prerequisites for femininity; to be insufficiently feminine is perceived as a failure in core sexual identity.[37] For example, Mattel's eternally popular *Barbie* is a

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[35] Lynde Birke, "Bodies and Biology," 45.

[36] Ibid., 47.

[37] Naomi Wolf claims that the feminine stereotype that has evolved in the last three decades has been predominately based on men's notions of an ideal women. Although there is an abundance of "beauty myths" prevalent in Western culture, Wolf claims that the beauty myth tells a story: "[T]he quality called 'beauty' objectively and universally exists. Women must embody it and men must want to possess women who embody it. An imperative for women and not men, it is necessary and natural because it is biological, sexual and evolutionary; strong men battle for beautiful women, and beautiful women are more reproductively successful. Women's beauty must correlate to their fertility, and since this system is based in sexual selection, it is inevitable and changeless" (2-3). She contends the myth has three composite parts; first it has been designed to divide women through competition; secondly it has put constraints on a female's self esteem as her identity was premised on her beauty and lastly, the myth was depicted on a massive scale through the media. "The beauty myth, in its modern form, arose to take the

beautiful, seductive, innocent, white, young, rich, thin and desirable women serving as the quintessential icon for contemporary culture's definition of ideal femininity. Women's internationalization of what constitutes beauty is reproduced by the unquenchable thirst to achieve this ideal of femininity.[38] Examples abound. An alarming twenty-four percent of Canadian women claimed they would shave three years off of their life to obtain their weight goals.[39] In the two year period between 1994 and 1996, the national average on esthetic surgery experienced a staggering increase; tummy tucks went up 103 per cent; breast augmentation increased 123 per cent; breast lifts rose 60 per cent; chemical peels grew 47 per cent; retina-A anti-wrinkle treatment was up 256 per cent; buttock lifts rose by 146 per cent and thigh lifts went up 93 per cent.[40] And incredibly, women support a forty billion-dollar diet industry every year, which does not include diet pills, diet foods or diet cookbooks.[41] While the ideal women is of course a product of science fiction, new forms of technology have allowed socially constructed ideals to move from the outer exterior of women's biological body into the inner space of women, altering the biological organism from within. The shift from social control to medical control thus appears seamless, fragmenting women's bodies into isolated parts, (breasts, legs, eyes, ovaries) and isolated functions (reproductive, neurological), which each fractured segment assigned a difference expert (gynecologists, neurologists, plastic surgeon). Under the gaze of technology women's bodies are medically reconstructed to conform to social norms. Plastic surgery for

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place of the feminine mystique, to save magazines and advertisers from the economic fallout of the women's revolution." See: Naomi Wolf, *The Beauty Myth* (Toronto: Random House,1990), generally.

[38] I am not advancing a 'docile body' thesis here, but I am rather punctuating the manner in which the internalisation of patriarchal cultural norms serves to disempower women and seek to turn women against their own bodies. For a discussion of the docile body see: Sandra Lee Bartky, "Foucault, Femininity, and the Modernization of Patriarchal Power" in *Feminist Social Thought: A Reader*, Diana Tietjens Meyers, ed. (New York: Routledge, 1997), 93-111.

[39] Celia Milne, "Pressures to Conform" in *Maclean's* (January 12, 1998), 61.

[40] Ibid.

[41] Ken Mayer, *Real Women Don't Diet!* (Maryland: Bartley Press, 1993), 80.

instance, acts as "a site of inscription, a billboard for the dominant cultural meanings that the female body" is expected to possess in contemporary culture.[42]

Feminist interpretations of Foucault's theory of bio-power are another useful instrument for fleshing out the various assumptions subsumed in the scientific paradigm, as they demonstrate how technological dogma is diffused throughout society and woven into our social, political and economic institutions. A number of feminist scholars have adopted Foucault's term bio-power to denote the shift "in the nature of the sovereign's power over its subjects, in which the state's focus on prohibition and judicial authority has been replaced by a new interests in the birth rate, education, discipline, health, and longevity of its population."[43] Under monarchal regimes, power was garnered through the continual threat of violence in which one individual had continuous control over the activities of another individual. In contrast, bio-power was constructed as a supposedly benign form of social control, which was actually laced with extremely insidious and contemptuous ideological underpinnings. As bio-power was diffused through society is took on two primary forms that were inexorably intertwined. As Jana Sawocki explains:

> One of these, disciplinary power, is knowledge of and power over the individual body – its capacities, gestures, movements, location, and behaviors. Disciplinary practices represent the body as a machine. They aim to render the individual more powerful, productive, useful *and* docile. They are located within institutions such as hospitals, schools, and prisons, but also at the microlevel of society in the everyday activities and habits of individuals. They secure their hold . . . [by] establishing norms against which individual and their behaviors and bodies are judged and against which they police themselves. The other form of bio-power is a regulatory power inscribed in policies and interventions governing the population. This so-called 'biopolitics of the population' is focused in the 'species body', the body that serves as the basis of biological processes affecting birth, death, the level of health and longevity. It is the target of state intervention and the object of study in demography, public health agencies, health economics and so forth.[44]

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[42] Anne Balsamo, "On the Cutting Edge: Cosmetic Surgery and the Technological Production of the Gendered Body" in *The Visual Culture Reader*, Nicholas Mirzoeff, ed. (New York: Routledge, 1998), 231.

[43] Monique Deveaux, "Feminism and Empowerment: A Critical Reading of Foucault" in *Feminist Interpretations of Michael Foucault*, Susan J Hekman, ed. (Pennsylvania: The Pennsylvania University Press, 1996), 218.

[44] Jana Sawicki, "Disciplining Mothers: Feminism and the New Reproductive Technologies" in *Feminist Theory and the Body*, Janet Price and Margrit Shildrick, eds. (New York: Routledge, 1999), 190-191.

The bio-power model exposes the multiple sources of women's disempowerment and broadens our focus far beyond political institutions and legislative authority. For instance, hyper-technology, which is a primary source of contemporary power, is ubiquitous, abstract and transcends any definitive explanations – it is everywhere and yet nowhere. Bio-power techniques create new forms of power that objectify health and sexuality as resources to be invaded, exploited and ultimately controlled.[45] Critical feminist practices must therefore identify how the artificiality and alterability of hyper-technology is managed and reproduced through a bio-power framework that is calculated into biology, medical practices and public policy. Viewed through this lens, the influence of hyper-technology on women's health and its association to empowerment are fundamental as it allows for the identification of multiple axes of oppression while retaining the ability to analyze and synthesize various power sources.

Traditionally, technology has been directly associated with tools and machines that symbolize signs of progress and degrees of 'civilization.' Contemporary culture however, is saturated with technological innovations that move beyond tools and machines and represent the human species increasing mastery of nature. Advanced forms of communication and surveillance, medicinal innovations and interventions, industrial machinery and corporate interests all represent the fashion in which technology has becomes interlaced with our everyday existence. Hyper-technology is thus distinct from traditional understandings of technology, where technology was associated with tools used by the human species to control their natural environment and garner resources from the earth. Vandana Shiva argues that the capitalist patriarchy has colonized, polluted and destroyed land, forests, the oceans and the atmosphere and must now seek out new territories to occupy and exploit. To accommodate its predatory appetite, hyper-technology has set its sights on "the interior spaces of the bodies of women, plants, and animals."[46] Hyper-technology is thus embroiled in the language of science and patriarchal conceptual frameworks, which are used to develop value dualism to confirm the human species mastery of nature. The scientific paradigm then

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[45] Nancy Fraser, *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory* (Minneapolis: University of Minnesota, 1989), 24.

[46] Vandana Shiva, *Biopiracy: The Plunder of Nature and Knowledge* (Toronto: Between the Lines, 1997), 45.

diffuses the logic of domination into the various disciplines, including the biomedical model. Women, who are viewed as being closer to nature, are then understood in the context of biological bodies and fractured physiological functions. The conceptual connection between women as body and men as mind further immobilizes women's power within society.[47] Scientific justifications of women's biology, which are mediated through technology, are thus significant sites of struggle over our bodies, our mind and our lives. As Donna Haraway articulates:

> Part of remaking ourselves as socialist-feminist human beings is remaking the sciences which constructs the category 'nature' and empowers its definition in technology. Science is about knowledge and power. In our time, natural science defines the human being's place in nature and history and provides the instruments of domination of the body and the community. By constructing the category nature, natural science imposes limits on history and self-formation. So science is part of the struggle over the nature of our lives.[48]

Feminist critiques of technoscience, while a fairly new terrain in feminist philosophy, provide an important analytical tool for explaining the manner in which women are forced to interact with medical technology and illustrate how scientific ideologies are metamorphosed into political agendas and social policy. In order to challenge traditional conceptualizations of 'healthy women' and destabilize assumptions cornering scientific objectivity the discourses surrounding scientific knowledge must be interrogated. According to Haraway, scientific knowledge is privileged knowledge in that it commands a captive audience through the use of the 'god-trick.' The god-trick refers to a process of knowledge construction in which science is viewed as an objective reality that can discover a particular truth through the use of technology. Understood in this context the god-trick determines what is relative and adopts the vision of this singular relativity as a universal truth. As Haraway explains:

> Science has always been about a search for translation, convertibility, mobility of meanings, and universality – which I call reductionism, when one language (guess whose) must be enforced as

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[47] The mind/body distinction initially arose from such ancient political philosophers as Aristotle, Hume and Plato. See: Elizabeth V. Spelman, "Woman as Body: Ancient and Contemporary Views" in *Feminist Theory and the Body*, Janet Price and Margrit Shildrick, eds. (New York: Routledge, 1999), 32-41.

[48] Donna Haraway, *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991), 43.

> the standard for all the translation and conversions. What money does in the exchange orders of capitalism, reductionalism does in the powerful mental order of global science: there is finally only one equation.[49]

The production of singular truth claims are thus extremely problematic in that they fail to reflect the manner in which social constructions constitute objective scientific knowledge. To capture the various dynamics and life situations that define women's health and their interaction with the medical establishment, feminists must recognize that knowledge is situated and is at best only partial.

Within the context of health, the operant framework for science and technology is the biomedical model. Adele E. Clarke and Virginia L. Olsen define the model as one that "centers on concepts of health status, health behaviors, and technoscience interventions. Gendered, cultured, historicized, and otherwise situated, women are routinely silenced or erased as actors in the production of health, in both the provisions and receipt of health care per se as well as in health politics and policy."[50] Inherent in the biomedical model is the medicalization of women's bodies and women's health. The medicalization of women's health originally occurred when the medical establishment entrenched itself as the only profession with the 'authority' to deliver health care, which in turn undermined the traditional non-interventionalist techniques customarily employed by women.[51] This provided doctors with the 'authority' to medically manage women's health and continues to dictate the power relations between practitioners and patients.

To understand how these complex and varied dynamics are established by the medical establishment, perpetuated by the state and encoded in public policy requires a number of theoretical tools from the feminist repertoire. For the purposes of this project, I have decided to use a framework provided by Elizabeth Grosz. Grosz argues that there are three specific forms of "intellectual misogyny" functioning within the

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[49] Ibid., 187-188.

[50] Adele E. Clarke and Virginia L. Olesen, "Revising, Diffracting, Acting" in *Revisioning Women, Health, and Healing: Feminist, Cultural, and Technoscience Perspectives,* Adele E. Clarke and Virginia L. Olesen, eds. (New York: Routledge, 1999), 3.

[51] Eleanor Maticka-Tyndale and Marilyn Bicher, "The Impact of Medicalization on Women" in *Social Control in Canada: Issues in the Social Construction of Deviance*, Bernard Schissek and Linda Mahood, eds. (Toronto: Oxford University Press, 1996), 152.

scientific paradigm; however, I would like to extend her analysis and suggest that these three forms of oppression can also be identified within the policy-making practices employed by the Canadian state.[52] The first form of discrimination she identifies is "sexism," which Grosz describes as the fashion in which scientific research, mythologies and practices function to privilege the male experience over the female experience. This form of misogyny is easily identifiable and can be challenged at a fairly simplistic level. The criminalization of abortion is a good example of a sexist health policy, in that it explicitly acted to oppress women by allowing the state to control personal decisions concerning women's bodies. The second form of misogyny Grosz distinguishes is "patriarchal knowledge" which operates as an "underlying structure regulating, organizing, and positioning men and women in places of different value and with differential access to self determination."[53] Patriarchy in the context of health care is evident in a variety of aspects; however, one of the most obvious manifestations of the past has been men's authoritarian and scientific role as doctors and women's caregiver roles as nurses. The final form of misogyny Grosz refers to is "phallocentrism," which is a discourse that operates by universalizing the male experience. Theories and research conducted under this guise view all subjects as undifferentiated by using masculine attributes as the referent for all human beings. Phallocentrism is difficult to identify because it acts as the "theoretical bedrock of a shared assumption that is so pervasive that it is no longer recognized."[54] Examples of phallocentrism within the field of health care occur at both the policy level and within the biomedical model. At the policy level, health care is designed to treat all citizens equally, which fails to recognize women's disproportionate responsibilities in caring for the health of their families. Within the biomedical model, men continue to be over-

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[52] Elizabeth A. Grosz, "The In(ter)vention of Feminist Knowledge" in *Crossing Boundaries: Feminism and the Critique of Knowledges*, B Caine, E.A. Grosz, and M de Lepervanche, eds. (Sydney and London: Allen & Unwin, 1988), 93.

[53] Ibid.

[54] Ibid., 94.

represented in those initiating research and the results of experiments performed specifically on men are often extrapolated to women.[55]

The importance of Grosz's typology of intellectual misogyny in a discussion of health care policy is twofold. First, health care policy pays a considerable amount of homage to the biomedical model and an allopathic approach, both of which are predicated on phallocentric claims about what constitutes truth, knowledge and health. Second, policy entrepreneurs in Canada continue to work within a patriarchal frame that often produces sexist outcomes. If women are to obtain, and then maintain, their full health potential there must be a sustained effort on the part of governments, the women's movement, policy architects, the medical establishment and feminist scholars to address and then integrate all of the dynamics that constitute 'health.' In order to demonstrate how these varied theoretical tools are all necessary in understanding women's experiences in the context of health I would now like to explore a concrete example that illustrates how these dynamics coalesce and impair women's empowerment. To this end I have chosen to examine new reproductive technologies, which will help to shed light on hyper-technology and its impact on women.

Practical Applications: New Reproductive Technologies and Old Science

Technology promises control, transcendence and the freedom for women to choice the manner in which they consume the various scientific innovations flooding contemporary culture. Or does it? The last fifty years have witnessed a proliferation of innovative medical devices, domestic equipment, new methods of communication, computer technology, and biomedical advancements, all of which would appear to benefit women. The benefits are superficial however, and if we unpack the various assumption embed in the scientific paradigm we quickly recognize that by its very 'nature' it is deeply patriarchal The love/hate relationship between women and technology is common, and as such, many feminist critiques have come in the form of retrospectives. For instance, second wave feminists heralded such birth controls

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[55] Marianne Van Den Wijngaard, *Reinventing the Sexes: The Biomedical Construction of Femininity and Masculinity* (Indianapolis: Indiana University Press, 1997), 50-51.

methods as the pill and the IUD as liberating saviors dissolving the yoke of women's biological functions. As Heather Menzies observes, "we bought into a particular definition of women's liberations which named the pill as the golden key. Uncomplainingly, we bore the price – the actual cost of pills and IUDs as well as the pain, the discomfort, and the mood swings."[56] The fallouts of these new technologies (increased risk of stroke, tubular pregnancies, blood clots and the scarring of the womb), however, illustrates that these particular innovations were entrenched in a scientific paradigm that continued to manifest a system of sexism despite its claims to neutrality and objectivity.[57] Feminists must therefore carefully interrogate any technology associated with women's health, as previous scientific innovations have exploited, medically managed and stigmatized every aspect of women's reproductive system. This section of the project will thus focus on the latest scientific innovations in women's reproductive lives – new reproductive technologies.

My primary concern in this portion of the thesis will accordingly be to demonstrate how the various theoretical tenets discussed in the previous section relate to the realities women face in their everyday life situations. While my aim is to highlight the ways in which the popular scientific paradigm serves to disempower women, I do not wish to demonize technology and science, nor do I intend to give it any organic quality. My own view is that science and technology are simply a reflection of that which the creator (the scientists) deems valuable and beneficial. As such technology is merely a byproduct of the culture that it represents, establishing it as irrevocably patriarchal and far too often oppressive. This should not, however, undermine the extraordinary advancements made by the medical establishment in treating human suffering and curing illness. Nonetheless, the scientific paradigm is so deeply imbued with phallocentric discourses and patriarchal agendas that it continually impairs women's full health potential and their access to power. Therefore, the practical example I have chosen reveals both the libratory and oppressive capacities of medical

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[56] Heather Menzies, "In His Image: Science and Technology" in Twist *and Shout: A Decade of Feminist Writing in This Magazine,* Susan Crean, ed. (Toronto: Second Story Press, 1992), 158.

[57] In other words, when these products were created there was very little research conducted on the effects and women were often not informed by their doctors of the risks associated with the Pill and using an IUD.

technology, while illustrating the manner in which these technologies mediate power relationships and position the medical establishment in a position of authority over women.

From Aristotle to Freud, social philosophers have argued that women's biological composition and their ability to reproduce influences their destiny.[58] A majority of the research and knowledge production emulating from the biomedical model gravitates around the study of sexual hormones, which reckons back to women being more closely associated with nature. Underlying ideological assumptions concerning masculinity and femininity are filtered into the scientific inquiry of hormones, eliciting the belief that male and female behaviors are directly correlated to hormonal impulses.[59] For women, hormonal composition was directly translated into a byproduct of their reproductive capabilities. Every stage of a woman's life became dictated culturally, emotionally, and medically, by hormonal changes associated with the reproductive process including menstruation, eroticism and menopause.[60] Feminists studying the biomedical model have explored the various connections and interactions that occur between the scientific construction of knowledge, the capitalist economy, and a societal view premised on androcentric assumptions. They have extensively documented how research on sex hormones has been transformed into pathologies, used as methods to control behavior, adopted as liberating mechanisms for women and eventually manipulated into various reproductive technologies.

Women's close association to nature, which has been developed culturally, socially and historically over the last three hundred years, has been predominantly premised on their reproductive abilities. Originally the bulk of the research focused explicitly on women's hormonal composition and associated reproductive abilities. With the advent of intrusive and exploratory medical technology the focus veered from simply studying fragmented aspects of women's physiological being to biological manipulation and reconfiguration. Today, the biomedical model seeks to dominate

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[58] Janet Sayers, *Biological Politics: Feminist and Anti-Feminist Perspectives* (London: Tavistock, 1982), 107-146, passim.

[59] Marianne Van Den Wijngaard, *Reinventing the Sexes,* 83-121.

[60] Nelly Oudshoorn, *Beyond the Natural Body: An Archeology of Sex Hormones* (New York: Routledge, 1994), 141-151.

women's reproductive capacities through the use of technology, which effectively alienates women from the reproductive process. Until fairly recently, reproductive technologies were only employed as a delivery mechanism or as preventative devises, however, today, these new technologies fully exploit women's bodies through invasive and reductionist processes. Numerous feminist scholars and activists have argued that reproductive technologies, and in particular new reproductive technologies, are profoundly powerful new tools being employed to dominate women scientifically and culturally. Scientifically, new reproductive technologies allow for the creation and manipulation of the human species through calculated scientific experimentation - realized ectogenesis. Culturally, women's subordinate status in society is advanced through "the direct devaluing and dehumanization of women," "through the transformation of reproduction as a patriarchal artifact" and "through the experience of coerced volunteeriness."[61] These two forms of domination inherently lead us to question the power structures and relationships involved in developing and disseminating the new reproductive technologies.

Before proceeding it is necessary to provide a cursory explanation of the technologies under investigation. In general, reproductive technologies are divided into four specific areas. First, there are various medications and procedures designed to control fertility, such as contraceptives and abortions.[62] The second grouping is associated with the use of fetal monitoring and labour-inducing drugs, which are considered the tools for the 'management' of labour and childbirth.[63] The next category involves prenatal technologies and includes ultrasounds, sex selection, and surgical treatment of the *foetus in utero*.[64] Finally, the category of technology that is considered 'new' includes in vitro fertilization, artificial insemination and surrogacy.[65] Although

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[61] Kathryn Pauly Morgan, "Of Woman Born? How old-Fashioned! – New Reproductive Technologies and Women's Oppression" in *The Future of Human Reproduction*, Christine Overall, ed. (Toronto: The Women's Press, 1989), 65.

[62] CRIAW, *Reproductive Technologies and Women: A Research Tool* (Ottawa: CRIAW/ICREF, October, 1989), 2.

[63] Ibid., 2-3.

[64] Ibid., 3.

this thesis will concentrate on the last category of technology, it is essential to recognize that all four areas are inexorably intertwined, which produces circumstances that assign medical experts a perpetually increasing degree of control over female's reproductive experiences and choices.

For many Canadian women, the ability to conceive children is an empowering and spiritual experience, however, for approximately 10 percent of Canadian couples, this objective is unobtainable due to infertility.[66] In the recent past, the scientific and medical authorities have responded to the needs of these infertile couples with the development of NRTs. The only technology that is actually 'new' is in vitro fertilization. The ideas of contract motherhood and artificial insemination have been in practice since the 1930's.[67] Despite the origins of the assisted reproductive technologies, the techniques and procedures have evolved and advanced. Before defining the three types of NRTs in detail, a distinction should be made between infertility and sterility. Infertility does not mean that an individual is unable to procreate; instead it means that it will take longer for that person and their partner to get pregnant.[68] In contrast, sterility is the incapacity to conceive. With this differentiation in mind, it should be reiterated that NRTs are a treatment for infertility, not sterility.

The most advanced technology in the repertoire of infertility treatments is the proverbial 'test-tube baby' clinically referred to as in vitro fertilization (IVF). This procedure combines the egg and sperm in a test tube or controlled laboratory setting. The egg incubates and the subsequent embryos are transferred to the women's uterus.[69] The procedure is time consuming, expensive and complex. First, the woman is administered a fertility drug, stimulating egg production in the ovaries. Next, a variety

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[65] Ibid.

[66] Gouvernement du Québec & Couseil du statut de la femme, *Dilemmas: When Technology Transforms Motherhood* (Québec: Les Publications du Québec, 1987), 4.

[67] Michelle Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood" in *Reproductive Technology: Gender, Motherhood, and Medicine*, Michelle Stanworth, ed. (England: Polity Press & Basil Blackwell, 1987), 11-14.

[68] CRIAW, "Infertility and Sterility" in *Women Look at the New Reproductive Technologies: Our Babies . . . Our Bodies?* (Ottawa: CRIAW/ICREF, 1989), 1.

[69] Arthur L. Wisot, M.D. and David R. Meldrum, M.D., *New Options for Fertility: A Guide to In Vitro Fertilization and Other Assisted Reproductive Methods* (New York: Pharos Books, 1990), 97.

of methods for retrieving the eggs are employed, all of which require anesthesia.[70] Sperm retrieval from either the male partner or a suitable donor depends on compatibility and sperm activity counts.[71] The sperm and the eggs are then brought together in the laboratory, where they will be incubated until insemination. In the next stage, which occurs between twenty-four and forty-eight hours after insemination, the fertilized eggs are placed in the women's uterus and the embryo is monitored from there. The success rate of this procedure is quite low, as fewer then 20 percent of the embryos implant properly and even less survive the full term of pregnancy.[72]

Another popular method of reproductive technology is artificial insemination (AI), which allows a woman to become impregnated without having sex. There are three types of insemination; AI using sperm from a donor, AI using sperm from the female's male partner and AI using a combination of both a donor's sperm and the partner's.[73] This procedure boasts a success rate of 70 to 75 percent with few congenital birth defects or complications.[74] A majority of inseminations are done using anonymous donor sperm that has been purchased.

Surrogacy or contract motherhood is less a form of technology than it is a legal and economic arrangement; however, both the medical establishment and policy makers have classified it as a new reproductive technology. A surrogate mother is artificially inseminated with the sperm of a man whose partner is sterile or unwilling to carry a child to term. Upon conception of the child, the surrogate mother turns all legal and parenting rights over to the couple.[75] 'Wombs for rent' through either private contractual agreements or brokers and commercial agencies are considered a dangerous venture by many feminists, in that such arrangements diminish the female role to that of

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[70] Ibid., 101.

[71] CRIAW, "In Vitro Fertilization" in *Women Look at the New Reproductive Technologies: Our Babies . . . Our Bodies?* (Ottawa: CRIAW/ICREF, 1989), 3.

[72] Wisot, *New Options For Fertility,* 105-106.

[73] CRIAW, "The New Reproductive Technologies" in *Women Look at the New Reproductive Technologies: Our Babies . . . Our Bodies?* (Ottawa: CRIAW/ICREF, 1989), 1.

[74] Joan H. Rollins, *Women's Minds, Women's Bodies: The Psychology of Women in a Biosocial Context* (New Jersey: Prentice Hall, 1996), 406.

[75] Michelle Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood," 17.

a carrier whose childbearing abilities are marketable and whose offspring is nothing more then a commodity.[76] Commonly, commercial surrogacy places pressures on poor women to rent their womb or their ova for economic reasons.[77] For instance, several American corporations have set up agencies that recruit large numbers of underprivileged women from developing countries and transport them to North America to offer reproductive services as 'cut rates.'[78] Somer Brodribb articulates the process as "an ideological device reflecting patriarchal interests" which are "based on a male consciousness of the birth process."[79] For many feminists such arrangements of surrogacy motherhood are better understood as reproductive slavery than reproductive technology.[80]

The scientific and technological research surrounding reproductive health has expanded at an exponential pace in the past twenty years, bringing with it an explosion in knowledge and the associated social, ethical, legal, economic and medical considerations. While all NRTs provide men and women, struggling with infertility, alternative methods by which to conceive, the health risks associated with these procedures are numerous. The medical and scientific establishments believe that these advancements have provided an invaluable service to infertile couples and they exonerate these developments as a tremendous step in humankind's natural evolution. In contrast, feminist scholars and organizations representing women's interests are concerned about the eventual uses of genetic manipulation, sex selection and other practices that could have a harmful effect on both women's health and society. Like a majority of new scientific research, current diagnostic capacities with respect to the fetus and the female reproductive system have the potential for both positive and

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[76] Ibid., 2.

[77] The National Action Committee on the Status of Women, "A Technological Handmaid's Tale" in *The Womanist*, vol.2, no.3 (Winter 1991), 36.

[78] Ibid., 37.

[79] Somer Brodribb, "Delivering Babies: Contracts and Contractions" in *The Future of Human Reproduction*, Christine Overall, ed. (Toronto: The Women's Press, 1989), 140.

[80] Rollins, *Women's Minds, Women's Bodies,* 408.

negative results. One of the gravest concerns facing feminists is the use of new gene technology in relation to NRTs.

The hallmark of gene manipulation occurred in 1970 when Dr. Richard Seed, a physicist and Dr. Randolph Seed, a surgeon, successfully transferred embryos between two cows. Soon after, the two brothers founded Fertility and Genetics Research Inc., a research center that financed the team of physicians who, in 1984, created the first flush-embryo baby (by removing an embryo from one woman and transferring it to the womb of another). When Dr. Richard Seed was questioned about the uses of embryo manipulation he suggested, "it would start therapeutically" but would eventually be used to "control human evolution."[81] As was suggested earlier, humanity's desire to control human evolution is a product of the human desire to master nature, however this form of domination threatens to be particularly insidious and reckons back to the eugenics movement of the early part of the 20th century. In Canada, the leading eugenics reformists were physicians who espoused racist, classist, xenophobic sentiments aimed at particular segments of society. These doctors claimed that social problems stemmed from medical problems, and as such the human race could be improved by controlling the reproductive activities of 'deficient' citizens.[82] For instance, in the 1920s and 1930s the British Columbian and Alberta legislatures passed sterilization acts that controlled the reproductive capacity of intellectually challenged individuals, of those sterilized, an overwhelming percentage were women.[83] Although these laws have since been rescinded and contemporary Canadians typically reject ideologies arising for Social Darwinism, many feminist scholars argue that the medical control of reproduction in the past, represents only a fraction of the patriarchal terror technology is currently ushering into the present. Under the umbrella of biotechnology

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[81] Gena Corea, "How the New Reproductive Technologies Will Affect All Women" in *Reconstructing Babylon: Essays on Women and Technology*, H. Patricia Hynes, ed. (Indianapolis: Indiana University Press, 1991), 42.

[82] For a full description of the eugenics movement in Canada see: Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland and Stewart, 1990).

[83] Wendy Mitchinson, "Medical Treatment of Women" in *Changing Patterns: Women in Canada*, 2nd ed. Sandra Burt, Lorraine Code, and Lindsay Dorney, eds. (Toronto: McClelland and Stewart, 1993), 412.

the current practices of genetic engineering are divorced from the vulgar discourses associated with the eugenics movements and relocated in the preferred paradigm of new reproductive technologies. As Rona Achilles suggests:

> The commercialization of reproductive capacities is inextricably linked to eugenics issues. Through commercialization, the child becomes a commodity, the recipient parents become consumers, and the gamete donors and contractual mothers become suppliers. Damaged or defective 'products' – babies who are not 'perfect'- will likely be unacceptable to the consumer . . . Medical control over these technologies is already well established and is solidified by recommendations in government reports.[84]

In other words, the reductionist formulas put forth by advocates of NRTs today, are little more than eugenics rhetoric under the guise of technological innovation and scientific advancement. The urgency for feminists to cultivate a critical approach to unmask the deeply embedded patriarchal and racist assumptions associated with these new technologies is paramount to the project of empowerment.

The project of women's empowerment and the development of a feminist praxis will thus require feminists to recognize the various points of oppression women encounter in their everyday lives and to extend their critiques of NRTs beyond simple gender analysis to encompass class, race, ablism sexual orientation and so forth, which all serve to situate women in different locations within society. Race and class in particular will inevitability influence women's experiences with NRTs.[85] As Dorothy Roberts argues, "[r]eproductive freedom is a right that belongs to all women; but its denial is felt the hardest by poor and minority women."[86] Examined through a raced and classed lens, the proliferation of NRTs is problematic and in some cases dangerous. For instance, many of the NRTs are expensive and as such only available to those women who can afford the procedures. A second concerns stems from the impact and discourse surrounding NRTs, which vary depending on the cultural perspective through

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[84] Rona Achilles, "Assisted Reproduction" in *Changing Patterns: Women in Canada*, 2nd ed. Sandra Burt, Lorraine Code, and Lindsay Dorney, eds. (Toronto: McClelland and Stewart, 1993), 509.

[85] Carolyn Egan and Linda Garnder provide a plethora of examples illustrating how racism affects the reproductive freedom of marginalized women. See: Carolyn Egan and Linda Garnder, "Racism, Women's Health, and Reproductive Freedom" in *Scratching the Surface: Canadian Anti-Racist Feminist Thought*, Enakshi Dua and Angela Robertson, eds. (Toronto: Women's Press, 1999), 295-307.

[86] Dorothy E. Roberts, "The Future of Reproductive Choice for Poor Women and Women of Color" in *The Politics of Women's Bodies: Sexuality, Appearance, and Behaviour*, Rose Weitz, ed. (Oxford: Oxford University Press, 1998), 271.

which is analyzed. For instance, Western feminists discuss reproductive technologies within the context of reproductive choice and freedom, while women in the South experience the same technologies as oppressive and coercive measures of social control. Navsharan Singh contends that while "intervention may expand the rights of some women, they reduce the rights and options of most women."[87] Singh argues that the discourses produced by Western feminists ignore the manner in which such technology can be employed as a mechanism of oppression through state intervention, especially under the rubric of population control. She criticizes the Western feminist analysis of failing to recognize that it is marginalized women from the South that "bear the brunt of these technologies."[88] One need not look far to find evidence supporting Singh's conjectures. For instance, the forced sterilization of approximately 40 percent of Indian women in the 1970s has been extensively documented by scholars whose studies concentrate on women in developing countries.[89] Thus, feminist postulations concerning the benefits and freedoms being offered by NRTs must be sensitive to the racialized and ethnocentric dimension of these new technologies.

At this point, the various insights provided above will be combined to develop a theoretical feminist perspective on technoscience that illustrates the importance of emphasizing the multiple dimensions of NRTs as opposed to the linear approach propagated by the medical establishment. As the preceding analysis has shown, the biomedical model is irrevocably patriarchal. The complexities and dynamics surrounding the issues of reproductive technologies are infinite. While certain forms of medical intervention into pregnancy, such as the pill and abortions, were heralded as triumphant victories for the women's movement, new technologies such as AI and IVF are very suspect and threaten to pose unforeseeable health risks to women. It is clear that the research methods and current therapeutic practices associated with NRTs represents a phallocentric discourse that has been established on the assumption that

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[87] Navsharan Singh, "Of Victim Women and Surplus Peoples: Reproductive Technologies and the Representations of 'Third World' Women" in *Studies in Political Economy*, vol. 52 (Spring, 1997), 156.

[88] Ibid., 157.

[89] Vandana Shiva and Maria Mies, *Ecofeminism* (Halifax: Fernwood Publications, 1993),190.

women are closer to nature and may therefore be dominated by the man of science. Upon this edifice of knowledge, various scientific technologies are manufactured to extend the predatory grip of the medical establishment into the reproductive lives of women. The biomedical model is further normalized by the dissemination of biopower throughout Western society, which dictates women's sexualized identities and regulates their bodily autonomy. This powerful form of social control determines women's status within a capitalist, patriarchal society defining both their productive and reproductive labour. Finally, any analysis on NRTs must be sensitive to the discursive spaces in which women are located, recognizing that different women will be differently affected by the new technology.

Feminist theories concerning biopower serve a dual purpose in understanding how NRTs serve to impair women's empowerment in relation to their health. First, biopower constitutes a self-regulating subject that can be inserted into the machinery of capitalism and whose productive activities are controlled by disciplinary power within which the subject has been indoctrinated. Second, patriarchal power is asserted over women's bodies through the technical innovations and scientific discourses developed to control the machine of reproduction. NRTs epitomize a contemporary set of discourses that are concerned with controlling women's reproductive functions to maximize the usage of women's bodies. Situated within the context of the New World Order, such technologies exploit the female body through invasion and regulatory mechanisms.[90] They seek to produce a social consciousness in which infertility is associated with an individual woman, as opposed to a societal problem stemming from environmental factors or conditions of poverty. Women's reproductive capacities are regulated and disciplined through state invention and medical meddling. Finally, biopolitics saturates women's psyche with hegemonic norms that become attached to their specific identity, such as mother, worker or sexual object. The continued

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[90] Ibid.

development of NRTs perpetuate women's submissive role in the natural processes of their own bodily functions.[91]

As has been suggested, technology, science and medical research have all come to symbolize the progress and development of an advanced industrializations society. These notions of progress must be reevaluated and deconstructed to identify the inherent power structures upon which they are premised.[92] Further, various aspects of NRTs such as contract motherhood, sperm donation, and egg and embryo selling, signal the beginning of a reproductive industry serving the interest of capital through the promulgation of reproductive technologies.[93] The failure to recognize the disparate ways in which reproductive technologies influence the life-situations of all women will allow policy entrepreneurs to perpetuate regulatory frameworks that fail to recognize the raced and classed dimensions of NRTs.

Feminist scholarship must further explore the relationships between scientific research and commercial interests. There must be a concerted effort to reveal the manner in which "those who control biotechnology also control its images and how we make sense of it."[94] Women must aggressively question why all the technologies are

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[91] Within the feminist community theories on reproduction and the socially induced desire pushing women to have children abound. The various intellectual currents are too numerous and to complex to adequately discussed in this project. However, there are several perennial tenets in these theories. First, women's desire to mother is not a product of biology. Second, a complex nexus of social agents operate to continually reinforces women's 'duty' to have children and care for them. Third, most theorists argue that the process of mothering is intrinsically tied to a capitalist economy in which women's unpaid labour acts as the invisible infrastructure upon which a new generation of workers are born and prepared to perform in the capitalist economy. Finally, most feminists recognize that the process is not only gendered, and also has racial dimensions and class distinctions. See for example: Nancy J. Chodorow, *Feminism and Psychoanalytic Theory* (New Haven and London: Yale University Press, 1989); Nancy J. Chodorow, *The Reproduction of Mothering*, with a new preface (Berkeley: University of California Press, 1999); Sara Ruddick, "Maternal Thinking" in *Women and Values*, 3rd ed. Marilyn Pearsall, ed. (United States: Wadsworth Publishing Company, 1999), 110-120; Kate Young, Carol Wolkowitz, and Roslyn McCullagh, eds., *Of Marriage and the Market: Women's Subordination Internationally and its Lessons* (New York: Routledge, 1981).

[92] Soheir Morsy, "Biotechnology and the Taming of Women's Bodies" in *Processed Lives: Gender and Technology in Everyday Life*, Jennifer Terry and Melodie Calvert, eds. (New York: Routledge, 1997), 171.

[93] Patricia Spallone, *Beyond Conception: The New Politics of Reproduction* (Massachusetts: Bergin & Garvey Publishers, Inc., 1989), 181.

[94] Annette Burfoot, "Technologies of Panic at the Movies: Killer Viruses, Warrior Women and Men in Distress" in *Reclaiming the Future: Women's Strategies for the 21st Century*, Somer Brodribb, ed. (Toronto: Gynergy Books, 1999), 125.

directly aimed at 'fixing' women when men's infertility is just as common. Women's organizations must reevaluate notions of reproductive freedom. Certainly, such reproductive options as the pill and abortions are fundamental aspects of women's bodily autonomy, however, NRTs are not universally available due to costs and accessibility and as such, feminists should question "why are [women] given some 'choices' and not others, and why are certain women allowed to decide among a particular set of reproductive options, while other women are not."[95] Reproductive freedom should mean freedom from coercion, freedom from abuse and freedom to chose, in other words it should empower women. This is not the case however, as advanced forms of medicalization over women reproductive capacities are exemplified by the biomedical model's ability to regulate women's bodily functions by defining what is natural, what is healthy and what is considered 'normal.'

For the most part, biotechnology is worshiped as the new golden calf of the scientific world. As Lorna Weir and Jasmin Habib punctuate, the Canadian state continually fails to consider the "trajectory of biomedicine and bioscience, taking it as in general unproblematic."[96] Feminist scholarship and grassroots activism must take into account the increasingly rapid development of biotechnology and the aggressive funding large pharmaceutical interests are funneling into new medical innovations and diagnostic techniques thereby establishing a close relationship between "the public health care system, research bioscience, the medical profession and capital."[97] The replacement of traditional obstetrics and gynecology with reproductive biology (which locates in roots in biotechnology), bioscience, and genetics has generally been left uninterrogated by feminist perspectives.[98] As Anne Donchin suggests: "There is a need now to integrate grass-roots feminist concerns about medically controlled reproduction

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[95] Spallone, *Beyond Conception,* 83.

[96] Lorna Weir and Jasmin Habib, "A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies" *Studies in Political Economy*, vol.52, Spring, 1997, 143.

[97] Ibid., 145.

[98] Ibid., 149.

with feminist theories' attempts to reconstruct the social framework of women's collective past and draw out connections to a possible feminist future."[99]

A clear understanding of how women's biological functions are viewed as closer to nature and thus vulnerable to control and exploration is fundamental to recognizing the manner in which these new technologies impair women's empowerment. Feminist theories have provided abundant evidence revealing how the dominant scientific paradigm is deeply imbued with patriarchal models and premised on phallocentric discourses. The patriarchal conceptual frameworks, which are invoked to determine the uses and authority of the new technology, are perpetuated through the logic of domination absorbed into both the state and popular culture. Previous uses of social control that disciplined women's biological bodies are now entering the interior spaces of women's biology and manipulating women from within. Feminist theories concerning NRTs ferret out the negative implications associated with these new scientific innovations, while grassroots activists empower women through education and alternative avenues of choice. Both are fundamental to protecting women's biological bodies and contesting NRTs locations within the dominant paradigm of hyper-technology.

Praxis: Behind Door Number One

Science and technology are ineluctably political and acutely complex, but they are not outside women's capacity for contestation. Throughout the historical vicissitudes of science there has never been a moment when technology was not intricately interwoven within the fabric of culture. Hyper-technology should thus be understood as the modern manifestation of the intermingling of science, technology, capital and power. Its historical location dictates its authority and reflects the sexist, racist, homophobic environment in which it was bred. Therefore just as patriarchal power is diffused through society and absorbed into the public consciousness, so too is hyper-technology disseminated as an omnipresent force. Hyper-technology is thus an

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[99] Anne Donchin, " The Future of Mothering: Reproductive Technology and Feminist Theory" in *Women and Values: Readings in Recent Feminist Philosophy*, 3rd ed. Marilyn Pearsall, ed. (California: Wadsworth Publishing Company, 1999), 122.

important characteristic of modern patriarchy and must be challenged just as vehemently and with as much vigor as other more popular areas of feminist research. Women's empowerment necessarily requires us to explore all dimensions of the matrix of power and interrogate those aspects that seek to impair women's freedom, health and choices. The creation of a formula that accounts for the various axes of oppression and seeks to provide women access to power is thus paramount for the feminist project. Feminist praxis allows for the creation of such a recipe.

As both feminist scholars and women-centered activists enter the corridors of hyper-technology our first task will be to determine those aspects of science and technology that may empower women and those facets that serve to oppress. In many ways, technology has already exhibited a remarkable ability to empower previously silenced voices, for instance, the internet's capacity for uniting progressively thinking people from across the globe. While technology in and of itself should not be misidentified as inherently evil or dangerous, the scientific paradigm of which it is a product should come under the continual interrogation of feminist scholars. The intellectual frame provided by those feminists who critique technology assists us in drawing a cognitive map of appropriate activism and methodologies for empowering women. At the academic levels these insights direct future research and promote the expansion of feminist techno-science critiques. At the grassroots level, the women's movements must continue to cultivate a critical approach to medical practices and technological interventions into women's biology. In the past, the Canadian women's movement has been very fluid, reflecting the shifting social and economic realities of Canadian women in the various historical epochs. Today, it must continue to evolve and reshape itself to address the manner in which hyper-technology is being used as a new form of patriarchal control.

Chapter Two

Shifting Paradigms: State Forms, Citizenship Regimes, and Girl Power

It is precisely this complex dialectic of the intensification and erosion of gender that provides the greatest challenge for the women's movement in the 1990s and beyond. And its response should neither be acquiescence nor resignation. Indeed, both the first and second wave of Canadian feminist struggled within and against different state forms in order to insert considerations of gender into an otherwise phallocentric politics. The current era of restructuring invites the women's movement to imagine alternatives to regressive neoliberal governing practices and to build new social consensus about a more equitable gender order. The future may be dangerous but it is also open.

- Janine Brodie [100]

Introduction

Empowerment requires agency and those forces working to detract from women's agency serve to profoundly undermine the feminist project. In the previous chapter I considered the myriad forms of oppression and domination emanating from the creation and dissemination of hyper-technology. I focused explicitly on women's biological agency and argued that hyper-technology impairs women's empowerment and denies their full health potential. This chapter will continue to concentrate on women's empowerment through the development of feminist praxis; however, the focus will shift from biological agency to political and social agency. Women's political and social agency has metamorphosed through a number of stages, all of which can be correlated with the ebb and flow of state policy and those hegemonic norms associated with particular eras. To account for these variations, feminist theories cornering citizenship, state formulations, and policy agendas have expanded considerably in the past hundred years. As the Canadian state evolved and grew, so too did the policy agenda and social programs available to the citizenry. In addition, several different

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[100] Janine Brodie, "Restructuring and the Politics of Marginalization" in *Women and Political Representation in Canada,* Manon Tremblay and Caroline Andrew, eds.(Ottawa: University of Ottawa Press, 1998), 34-35.

discourses emerged concerning the social contract and the traditional liberal partition between the public and private spheres. This chapter will explore these varied dynamics and determine the manner in which they have affected women's empowerment. To accomplish this task, I will consider women's full citizenship as a necessary prerequisite to women's empowerment.

This chapter begins by tracing the evolution of feminist citizenship theory and defining a feminist citizenship praxis that is appropriate for the contemporary situation in Canada. Next, I will turn to an examination of the various state forms indicative of Canada's past and present. In developing my model of the neoliberal state, I draw heavily from the scholarship of Janine Brodie who provides a number of theoretical tools for understanding the complex dynamics coupled with the shifting paradigms of the Canadian state. Specifically, this section of the chapter will focus on the neoliberal state and associated neoconservative ideas. To illustrate the theoretical conjectures I discuss, I explore the strategies and challenges facing the Canadian women's movement in the current political climate. Once again, my primary goal is to outline a feminist praxis that addresses the synergistic affects of neoliberalism, neoconservative and hyper-technology and delineates a path towards women's empowerment.

Theory: Pendulum Swings

At the dawn of the new millennium feminist theories face a number of new challenges, in addition to the perennial struggle of countering the biases of the patriarchal state. Discussions of citizenship play a prominent role in developing a feminist praxis as citizenship allows for theoretical articulations of inclusion and develops practical agendas for participation in political activities. However, feminist citizenship praxis faces the difficult task of reconciling equality and difference in an anti-essentialist framework. As such, feminist theories focused on citizenship must explain and critique the inclusionary and exclusionary strategies of the state, while responding to women's multiple identities and diverse social locations. In the words of

Ruth Lister, "feminist citizenship praxis has to ride the tension between the universal and the particular."[101]

Feminist citizenship theories were initially concerned with equality, focused on the political task of women acquiring the same rights as men in all spheres of life. For the most part scholarship promoting equality was focused on the sexist structures of the state and the invisibility of women's role in the private sphere. The equality perspective viewed gender as a social construct of male domination and believed "that to stress gender difference [was] to harm women."[102] The pursuant goal of equality feminists was to eliminate gender difference by arguing that women were the 'same' as men, and therefore equal to men. Strategies for achieving the goal of equality varied among the three predominant currents of feminism associated with this era (liberal, radical and socialist); however, despite their theoretical dissimilarities they all fought for the same end. The equality perspective dominated the feminist terrain until the late 1960s when the gender-neutral model of citizenship was challenged by a gender-differentiated model.

Feminists promoting the difference perceptive charged the previous citizenship theories focused on equality as oppressive mechanisms in that they ignored difference.[103] Difference feminists argued that women's citizenship based on equality with men reproduced women's subordination by establishing the male as the norm against which women's participation in the state would be measured. Theories of women's difference posited that women's participation, as full citizens, required recognition of gender difference and a reevaluation of femininity. According to Nancy Fraser, difference feminists sought to illustrate the manner in which women's sameness and women's difference required a rearticulation of citizenship that addressed women's different yet equivalent voices. As such, difference feminism was premised on the assumption that

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[101] Ruth Lister, *Citizenship: Feminist Perspectives* (New York: New York University Press, 1997), 197.

[102] Nancy Fraser, *Justice Interruptus: Critical Reflection on the 'Postsocialist' Condition* (New York: Routledge, 1997), 176.

[103] Sherene Razack, *Looking White People in the Eye: Gender and Culture in Courtrooms and Classrooms* (Toronto: University of Toronto Press, 1998), 158.

> All women shared a common 'gender identity' *as women*. All suffered a common harm when that identity was depreciated. All, therefore, were sisters under the skin. Feminists need only articulate the positive content of feminism in order to mobilize this latent solidarity. The way to do justice to women, in sum, was to *recognize*, not minimize, gender difference.[104]

Proponents of the difference perceptive viewed androcentrism as the chief antagonist of women's subordination, claiming that citizenship premised on equality simply assimilated women into traditional male activities. At the same time, the various articulations of difference and debates on 'inclusion' concerning women's citizenship, threatened to tokenize and divide women into a kaleidoscope of disparate groups occluding any opportunity for collective action.[105]

In the mid 1980s feminism was once again challenged from within, as mainstream feminists, of both the equality and difference perspectives, were accused of essentialism. According to these 'Other' feminists, many theories emanating from the dominant group appeared to manifest an apprehensive disposition when addressing issues of exclusion, essentialism and racism.[106] According to bell hooks, feminist epistemology must avoid the "commodification of difference," as it has the potential to translate into a representation, which threatens to ignore the existing power relations.[107] Thus, the challenge for contemporary feminist theorists is to address the cultural intersections between race, sexuality and class, while recognizing that inherent in the traditional feminist application of 'sisterhood' were racist and classist assumptions about womanhood. From this precarious location a new version of feminist citizenship has to be formulated, one which does not simply tolerate difference but directly, interacts with it, providing a voice for all women. A feminist citizenship praxis must therefore navigate between the equality and difference perspectives while weaving the

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[104] Emphasis in original. Fraser, *Justice Interruptus* , 176-177.

[105] Cyrania Johnson-Roullier, "Identity Politics, Feminism, and the Problems of Difference" in *Surfaces,* vol. II, no.108 (June 1997), 5.

[106] Sherene Razack suggests that the following feminist scholars fit this description: Naomi Shor, Jane Roland Martin, Catharine MacKinnon, Christina Crosby, Nancy Miller and Patricia Marchak. See: Razack, *Looking White People in the Eye,* 161-168, passim.

[107] bell hooks, *Black Looks: Race and Representation* (Boston: South End Press, 1992), 21.

other axes of difference including race, sexuality, ablism, class, ethnicity and age throughout the conceptualization.

To begin outlining the necessary parameters for a feminist citizenship praxis, this project will take advice from Iris Marion Young who constructs an anti-essentialist notion of citizenship by postulating gender as 'seriality' as opposed to analyzing women as a "homogenous group, which speaks with one voice and articulates collective goals."[108] Young distinguishes between a group and a series by suggesting that a group, specifically the group 'women' is recognized as a 'social collective' and in no way represents feminist politics. In contrast, a series is a collection of individuals, who hold one or more of race, class, ethnicity, age, abilities, financial restrictions, social activism, and political ideologies or goals in common.[109] As women 'the group' is dispersed along various axes of other groups (e.g. race, sexuality, class, and so on) the diverse forms of oppression each individual experiences become blurred.[110] However, by defining women as a social collective or a series, which does not specify the identity of particular individuals, a woman can identify as a lesbian and as an Aboriginal without having to carve her individuality into composite parts. As Linda Trimble explains, "being part of a series does not require identification of essential/bodily attributes which women share; it simply means that women are linked by structures like enforced heterosexuality and the sexual division of labour.'"[111]

In articulating precisely what a feminist citizenship praxis would entail, this thesis will adhere to a definition put forth by Ruth Lister. Lister advocates a conceptualization of citizenship that syntheses citizenship as a status and citizenship as a practice, punctuating the manner in which each understanding shares human agency as a common dominator. Reconciling the disparities between equality and difference in

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[108] Linda Trimble, "'Good Enough Citizens': Canadian Women and Representation in Constitutional Deliberations" in *International Journal of Canadian Studies*, vol. 17 (Spring 1998), 133.

[109] Iris Marion Young, "Gender as Serially: Thinking about Women as a Social Collective" in *Rethinking the Political: Gender, Resistance, and the State*, Barbara Laslett, Johanna Brenner and Yesim Arat, eds. (Chicago: The University of Chicago Press, 1995), 100-101.

[110] Ibid., 104.

[111] Trimble, "Good Enough Citizens,"133.

this manner necessarily requires an understanding of the traditional dichotomies set up to categorize women's citizenship in opposition to men.[112] These dualisms function by constructing men as superior and therefore, anything that has traditionally been identified as male is granted higher status.[113] The sets of dualisms developed by canonical political thinkers are of course the same binaries ecofeminists refer to as value dualism. Intrinsic to the establishment of these binary oppositions is the assumption that the left side of equation has authority over of the right side. The binary opposition of equality however is inequality, which expresses implicitly the affinity between equality and difference. Feminist struggles for equality are only necessary because men and women are unequal, which inherently suggests that they are different. Understood though this lens, women's claims to citizenship can purport the universal concept of 'woman' while recognizing the plurality of difference and the multiplicity of identities that women possess. Lister thus defines citizenship as "both a status, carrying a set of rights including social and reproductive rights, and a practice, involving political participation broadly defined so as to include the kind of informal politics in which women are likely to engage."[114]

A feminist citizenship praxis articulated in the preceding manner allows for both scholars and activists to create an agenda that embraces women's differences, while still allowing feminists to postulate universal claims. Further, the synthesis of theory and practice supports the collective goal of both the women's movement and the academy by seeking to establish women's full citizenship rights. Lister's citizenship model allows us to reconceptualization the social contract by addressing the asymmetric nature of neoliberal policy and the manner in which it operates in tandem with the global economic agenda. Finally, feminist citizenship praxis exposes women's historical and contemporary differential relationship with the state, challenging notions concerning the 'good enough citizen.'

Feminist theories of citizenship have varied through history, reflecting various state forms. Following the Second World War feminists scholars and activists expended

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[112] Ruth Lister, "Dialectics of Citizenship" in *Hypatia,* vol.12, no.4 (Fall 1997), 18-20.

[113] Carolyn Merchant, *The Death of Nature*, generally.

[114] Ruth Lister, *Citizenship: Feminist Perspectives,* 196.

a great deal of time and energy critiquing the welfare state and developing theories concerning women's status as second-class citizens within this state form. Citizenship during this era was associated with a limited version of T.H. Marshall's theory of social citizenship which "defined citizenship as 'a status bestowed on those who are full members of a community,' which includes civil, political and social rights and obligations."[115] This configuration of citizenship mediated the state-society relationship and promoted collective political activism among citizens providing various points of access to influence political decisions. In contrast, the ascendancy of neoliberalism in Canada has ushered in a new governing philosophy that dictates a different agenda to both policy entrepreneurs and political actors. Although this new agenda does advocate economic citizenship it severely erodes social citizenship. Therefore, feminist scholars face the formidable task of countering the hegemonic discourses of neoliberalism and neoconservatism and interrogating the sexist, patriarchal and phallocentric discourses that inform the governmentality of each state from.[116]

In Canada, the cleavages between women and men, poor and rich, non-white and white, homosexual and heterosexual have been expanding since the early eighties under the exigencies of economic restructuring and neoliberalism. To understand the new governing philosophy prorogated by the neoliberal agenda, the Canadian state must be examined in both an historical and cultural context. Janine Brodie suggests that both the past and current relationship between the state and society is a product of cultural representations and "impositional claims" which she defines as "assertions about reality which help to create a cultural form" of understanding "about what is natural, neutral and universal."[117] She applies a "social-constructionist lens" to illustrate that "women do not stand ahistorically outside a particular state formation, but instead, are historical

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[115] Nira Yuval Davis, "Women, Citizenship and Difference" in *Feminist Review*, no.57 (Fall 1997), 5.

[116] Wendy Sarvasy, "Social Citizenship from a Feminist Perspective" in *Hypatia*, vol.12, no.4 (Fall 1997), 54.

[117] Janine Brodie, "Meso-Discourses, State Forms and the Gendering of Liberal-Democratic Citizenship" in *Citizenship Studies*, vol.1, no.2 (1997), 226.

products of public policy and other cultural forms."[118] She argues that hegemonic norms are established and maintained through the 'meso-discourses' of the ruling elite. Brodie explains meso-discourses, as "an historical consensus about what is understood to be rational, progress, emancipation, justice, and so on. As such, they act as historically defined templates, which underlie a policy field, shaping the content and delivery of public goods, and allowing for a certain measure of coherence in state activities, identity formations and forms of political contestation."[119] Impositional claims are a core ingredient in any meso-discourse in that such assertions provide a foundation of understanding such societal notions as universality, neutrality and normalcy. Thus the state-society relationship is predicated on both cultural representations and impositional claims. For example, the meso-discourse of the traditional liberal state created and then maintained a universal consensus concerning the partition of the public sphere, which consisted of political and economic activities, and the private sphere, which was considered the familial and domestic realm. By establishing this dichotomy as natural and universal, social relations organized around gender were considered unchallengeable. As Brodie explains, the meso-discourse of the Liberal state "pronounced as 'natural' and, therefore a politically uncontestable complementary between social spaces and social relations, as well as between institutions and functions."[120]

Meso-discourses are important in the discussion of citizenship in that they act as an ideological infrastructure upon which regimes of citizenship are established. As mentioned earlier, state discourses on citizenship develop systems of inclusion and exclusion, which are entrenched into national institutions, policies, and the dominant ideological paradigms. These three factors work in concert to produce hegemonic norms concerning what full citizenship rights entail and who receives such privileges. Although periods of restructuring allow for contestation of these conceptualizations,

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[118] Janine Brodie, "Canadian Women, Changing State Forms, and Public Policy" in *Women and Canadian Public Policy* (Toronto: Harcourt Brace, 1995), 13.

[119] Janine Brodie, "Meso-Discourses," 227.

[120] Janine Brodie, *Politics on the Margins: Restructuring and the Canadian Women's Movement* (Ontario: Robarts Centre for Canadian Studies, 1995), 34.

state actors continue to propagate particular forms of thinking about citizenship. According to Jane Jenson and Susan D. Phillips:

> Each regime is forged out of the political circumstances of a national state. Being a regime, citizenship does not alter quickly or even easily. Nonetheless, it does change at moments of economic and political turbulence. In such moments of fundamental restructuring of the role of the state, the division of labour between state and market, between public and 'private,' and between civil society and the state are re-opened for discussion. Citizenship regimes also come under pressure at such times precisely because they are a crucial component of the model of development that, prior to the turbulent moment, has ordered social relations. When the model of development enters crisis, so does the citizenship regime embedded within it.[121]

As the Canadian state went through a dramatic period of restructuring following the Second World War, a new meso-discourse was assumed. The new discourse was closely associated with the Keynesian economic model and as such espoused new goals for the relationship between state and society, including full employment, an expansion of social services, and a new regime of citizenship. Brodie argues that the "postwar consensus held that the public could enforce limits on the market, that people were not forced to engage in market activities that denied their safety or dignity, and that the national community was responsible for the basic well-being of its individual members."[122] Although the introduction of the welfare state provided a more extensive definition of citizenship, the structures of the social safety net continued to be predicated on patriarchal norms. While there was a noticeable shift away from the sexist ideologies that drove the classic liberal state, the welfare state's adoption of a patriarchal model promoted a system that was deeply gendered, raced, and classed. Further, the organization of the welfare system created a hierarchy in which men were viewed as contributors to the system and thus were deserving of benefits, while women were viewed as clients and dependents.[123]

The new regime of citizenship, the economic process of restructuring and the meso-discourse determining the state-society relationship are all paramount features of the new neoliberal state. To understand how the diverse forces are operating and being

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[121] Jane Jenson and Susan D. Philips, "Regime Shift: New Citizenship Practices in Canada" in *International Journal of Canadian Studies*, vol.14 (Fall 1996), 113.

[122] Janine Brodie, "Restructuring and the New Citizenship" in *Rethinking Restructuring: Gender and Change in Canada*, Isabella Bakker, ed. (Toronto: University of Toronto Press, 1996), 130.

[123] Nancy Fraser, *Unruly Practices*, 147-151.

advanced in tandem, it would be advantageous to take direction from Wendy Larner's insight on neoliberalism as "governmentality." Larner maintains that there are three distinct understandings of neoliberalism including, a policy agenda, an ideology and a type of governing philosophy.[124] Larner suggests that although neoliberalism promotes limited government it also endorses a greater degree of governance, in that it "encourages both institutions and individuals to conform to the norms of the market."[125] The meso-discourses of the neoliberal system of governance thus encourage the establishment of a new citizenship regime that is based on an active society. In doing so, the welfare state's conceptualization of social citizenship was predicated on "a national community of citizens, made up of male breadwinner and female domestic workers, has been usurped by a new understanding in which not only are firms to be entrepreneurial, enterprising and innovative, but so too are political subjects."[126] Therefore, where the welfare state's understanding of citizenship promoted various social policies to address these differential accesses to the state, the neoliberal discourse is promoting a trend towards a greater degree of individuation.

Under the rubric of neoliberalism the state is abandoning the Keynesian model and adopting an agenda premised on deregulation, economical competitiveness, efficiency and minimal state intervention.[127] According to Brodie, this reconfiguration of the Canadian polity will usher in new forms of patriarchal and capitalist control and will disproportionately affect women as the state downloads responsibility into the private sphere. Brodie's understanding of the new citizenship regime is part of a general consensus among Canadian feminist scholars that citizenship must be viewed as a social construct that reflects, not only the governance mentality of neoliberalism, but also the underlying ideology of neoconservatism. Through this lens women-centered theorists are arguing that within the new citizenship regime, citizens are expected to take care of

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[124] Wendy Larner, "Neo-liberalism: Policy, Ideology, Governmentality" in *Studies in Political Economy*, vol.63 (Autumn 2000), 6.

[125] Ibid., 12.

[126] Ibid., 13.

[127] Janine Brodie, "Canadian Women, Changing State Forms, and Public Policy," 4-5.

themselves and those who fail to become self-sufficient are considered problematic and deviant.[128]

The final dimension of the new state form this project will explore is neoconservatism and moral regulation. Xiaobei Chen argues that there is a "dynamic interaction between neoliberalism and other ideas, such a neo-conservatism, in the making of social policy."[129] Take, for example, breast cancer. The amount of research and government monies being funneled into breast cancer research has grown exponentially over the last decade, however, the female patient that the research is geared towards is inevitably heterosexual. Although lesbians constitute between 5 to 10% of the Canadian female population, health services and information programs for these women are nonexistent. Informational material concerning breast cancer fails to even present a thinly veiled façade of inclusion (as many other government policies do) in that it uses gender specific language that speaks to a 'husband' and 'wife.'[130] Indeed a great deal of policy research is steeped in moral regulation and a "reinstatement of the principles of family."[131] Therefore neoconservatism, operating in concert with the new regime of citizenship and neoliberal governance, has attenuated the fiscal responsibilities of some social programs but strengthen the support of others. In addition, it has increased the degree of moral regulation on those persons who deviate from the hegemonic norm. As a result of these forces, Canadians are under siege from a variety of new arrangements that erode those social services and programs that characterized the welfare state.

Of these new arrangements, one of the most insidious has been the dramatic shift in social security, implemented in 1996 with the establishment of the new Canadian Health and Social Transfer (CHST). The introduction of the CHST came

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[128] Ibid., 21-23.

[129] Xiaobei Chen, " Is It All Neo-liberal? Some Reflections on Child Protection Policy and Neo-Conservatism in Ontario" in *Canadian Review of Social Policy,* forthcoming 2001, 1.

[130] Heather Ramsay, "Lesbians and Breast Cancer: Challenges and Concerns" in *Canadian Women Studies*, vol.14, no.3 (Summer 1994), 27.

[131] Sandra Burt, "Gender and Public Policy: Making Some Difference Ottawa" in *Gender & Politics in Contemporary Canada,* François-Pierre Gingras, ed. (Toronto: Oxford University Press, 1995), 103.

right on the heels of the new child tax credit, which collapsed family allowances, the non-refundable credit for dependent children and the refundable child tax credit into one child benefit.[132] In the past, the fifty/fifty cost sharing of social programs between the federal and provincial governments had been one of the principle aspects of the Canadians social welfare system. The introduction of CHST however, reorganized the transfer payment by combining "the federal funds marked for social assistance with the pre-existing block grant designed for health care and post-secondary education" which replaced "two of the foundational fiscal pillars of Canada's postwar social security system – the Canada Assistance Plan (CAP, 1966) and Established Programs Financing (EPF, 1977)."[133] The importance of the CHST for this project is the manner in which it illustrates the combined affects of the diverse dynamics that have been discussed. The results of the CHST have been devastating. As Maude Barlow suggests the political and economic agenda of neoliberalism "threatens basic rights already won" and will serve to terrorize marginalized Canadian citizens in a fashion that the women's movement has barely considered. [134]

For the wealthier provinces of British Columbia, Alberta and Ontario the federal government has placed a cap on the benefits they receive which has resulted in Ontario and Alberta reducing social assistance benefits and restructuring health care programs, labour legislation, and social services.[135] For instance, the Ontario conservative government of Mike Harris defined their mandate to be "income tax cuts; the conversion of the system of welfare to one of mandatory workfare; and the elimination

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[132] To a certain degree the introduction of the single child tax credit can be correlated with the increase in child poverty. Further, it increases the economic burden on low-income single-parent families. For a full description of the various implications see: Frances Woolley, Judith Madill and Arndt Vermaeten, "Credits in Crisis: Evaluating Child Benefit Reform in Canada" in *Feminism and Families: Critical Policies and Changing Practices*, Meg Luxton, ed. (Halifax: Fernwood Publishing, 1997), 60-79.

[133] Isabella Bakker and Janine Brodie, *The New Health and Social Transfer (CHST): The Implications for Women*, unpublished paper (Toronto: York University, 1995), 2.

[134] Maude Barlow, "Women and the Time Warp" in *Canadian Forum*, (September 1996), 9.

[135] Bakker and Brodie, *The New Health and Social Transfer*, 2.

of employment equality legislation."[136] In Alberta the Klein government has taken an especially draconian approach attempting to privatize health care and established a profit-driven medical model.[137] According to Kathleen O'Hara the majority of cuts to the social welfare system have been funneled into "wealthfare," a system that in 1991 allowed big Canadian business to wrote off more than $90 billion in tax expenditures.[138]

A plethora of other problems are also being spawned due to the introduction of CHST and the dictates of the neoliberal agenda. For instance, the new fiscal transfer has "reduced federal leverage in seeking to maintain nation standards."[139] Under the rubric of neoliberalism the medical establishment has adopted a new model of studying public health referred to as the 'population health' approach. This approach studies the health of an entire segment of society and views "social structures as crucial in shaping health and well-being."[140] However, the approach is framed in the language of neoliberalism and therefore ignores the impact of gender, race, sexual orientation, and ability on an individual's health. In addition, the new health care approach shifts the responsibility to the individual by suggesting that as good citizens, individuals should keep themselves healthy. Thus, Canadians are being inundated with material that tells us what not to do (smoke, drink alcohol and so forth) and what to do (eat well, exercise regularly). Those individuals who deviate from the wellness model often face various forms of discrimination from the medical establishment and in some cases are even criminalized.[141]

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[136] James Laxer, *In Search of a New Left: Canadian Politics After the Neoconservative Assault* (Toronto: Viking, 1996), 33.

[137] Kevin Taft and Gilliam Steward, *Clear Answers: the Economics and Politics of For-Profit Medicine* (Edmonton: Duval House Publishing/ Parkland Institute/The University of Alberta Press, 2000), generally.

[138] Kathleen O'Hara, "Corporate Wealthfare" in *Canadian Forum* (March, 1996), 16.

[139] Stephen McBride and John Shields, *Dismantling a Nations: The Transition to Corporate Rule in Canada*, 2nd ed. (Halifax: Fernwood Publishing, 1997), 135.

[140] Monica Townson, *Health and Wealth: How Fiscal and Economic Factors Affect Our Well Being* (Ottawa: Canadian Centre for Policy Alternatives, 1999), 12.

[141] For example the Supreme Court decision on the Ms. G. case. See: Deborah Rutman, Marilyn Callahan, Audrey Lundquist, Suzanne Jackson and Barbara Field, *Substance Use and Pregnancy: Conceiving Women in the Policy-Making Process* (Ottawa: Status of Women Canadian, August 2000).

As the burden of care is shifted from the public arena back into the private sphere women's unpaid labour is also increased. There is a general consensus among women's organizations that women's unpaid labour is the invisible infrastructure upon which capitalism is established. As has already been discussed, the neoliberal state manufactures an advanced capitalist system, which shifts an ever-increasing burden of responsibility into the domestic sphere and by extension into the hands of Canadian women. For the Canadian women's movement's "one of the central pre-occupation has been the way women's responsibility for domestic labour relates to their subordination."[142] The traditional goal of having women's unpaid labour understood by the state and shared with male partners has been developed extensively by Canadian scholars and will not be revisited in this project. I instead prefer to focus on the unpaid labour in the context of the neoliberal state. Although the unpaid domestic labour women perform has always supported the Canadian economy Isabella Bakker argues that there must be a connection made between domestic labour and the macro-economy within the context of neoliberalism. As has been the case, the macro level economy is highly dependent on women's unpaid labour; however, the use of gender-neutral language impairs the ability of the women's movement to make demands on policy entrepreneurs.[143] Therefore the data collected by the 1992 Time Use Survey conducted by Statistics Canada which found the value of unpaid labour to be at the between $210.8 billion and $318.8 billion (representing 30.6% and 46.3% of Canada's gross Domestic Product)[144] is ignored by the 1995 federal policy guide on equality.[145]

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[142] Meg Luxton and Leah F. Vosko, "Where Women's Efforts Count: the 1996 Census Campaign and 'Family' Politics in Canada" in *Studies in Political Economy*, 56, Summer, 1998, 50.

[143] Isabella Bakker, *Unpaid Work and Macroecnomics: New Discussions, New Tool for Action* (Ottawa: Status of Women Canada, 1998), passim.

[144] Status of Women Canada, *Toward a Framework for Evaluating the Policy Implication of Unpaid Work*. A paper presented to the Working Party on the Role of Women in the Economy of the Organization for Economic Cooperation and Development (Ottawa: Status of Women Canada, October 1995).

[145] Canada, *Setting the Stage for the Next Century: The Federal Plan for Gender Equality* (Ottawa: Status of Women Canada, August 1995).

Neoliberalism, operating as an active ideological force, has greatly inhibited the ability of the women's movement to contest the new state configuration, by labeling the movement as a special interest group that does not represent the popular public consciousness. As some feminist scholars have noted the neoliberal ideologues are using "the illusion that women have achieved equality [which] is almost as pervasive as the reality of oppression."[146] The attempt to undermine the validity of the movement was apparent in the extensive funding cuts experienced by NAC, the English Canadian women's movements' umbrella organization. Since 1986 NAC has received block funding from the federal government that equated to approximately 60 percent of its budget, however, NAC's government grants have been cut to project funding and the organization publicly stated in 1999 that it "was facing the prospect of closure."[147] The extended period of state restructuring during the postwar years provided the women's movement with an opportunity to voice a variety of concerns including women's involvement in the labour market, adequate social security, social citizenship and legal equality. According to Jane Ursel, "[t]his new ideology not only resulted in greater state activity, but also in a shift in emphasis from regulative to supportive government interventions" which was "largely a result of the introduction of universal programs."[148] However, the neoliberal agenda has been eroding the old type of welfare thinking at an exponential rate while at the same time undermining the legitimacy of the women's movement and feminist demands.

The CHST is indicative of the new meso-discourse in Canada, it is representative of both a neoliberal mode of governance and a neoconservative ideology, and it clearly punctuates the manner in which these forces are coming together in an attempt to reorganize the definition of citizenship in the Canadian polity. As a form of governance, the CHST highlights the manner in which "the corporate agenda is

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[146] Gwen Brodsky and Shelagh Day, *Canadian Charter Equality Rights for Women: One Step Forward or Two Steps Back.* (Ottawa: Canadian Advisory Council on the Status of Women, 1989), 11.

[147] Sandra Burt, "Canadian Women's Movements: Revisiting Historical Patterns and Considering Present Developments" in *Canadian Politics*, 3rd ed., James Bickerton and Alain-G. Gagnon, eds. (Ontario: Broadview Press, 1999),409.

[148] Jane Ursel, *Private Live, Public Policy: 100 Years of State Intervention in the Family* (Toronto: Women's Press, 1992), 252.

perpetuated by the federal government at the provincial level."[149] Take for example health care in Alberta where the Klein government is aggressively promoting a privatized approach to health services in order to establish a profit-driven medical model.[150] As an ideology premised on neoconservatism, the deinstitutionalization of health care services shifts the primary care from medical professionals to the unpaid labour of women in the domestic sphere.[151] Although the situation appears to parallel the breadwinner model that dominated the welfare state model, the new meso-discourse concerning the macro level economy uses gender-neutral language, which fundamentally impairs the ability of feminist interests to make demands on policy entrepreneurs.[152] Finally, the new citizenship regime redefines the "good citizen" as "one who recognizes the limits and liabilities of state provision and embraces her obligation to work longer and harder in order to become more self-reliant."[153] This reconceptualization of the state-society relationship adopts phallocentric language, which identifies all citizens as being equal and thus equally responsible for their own health care needs. Those who have 'special' needs are cast as deviant and are not in alignment with the good citizens who are able to take care of themselves.

In summation, women's empowerment is harmed by a plethora of factors emanating from the new neoliberal state and the underlying neoconservative ideas. The current task for feminist scholars is thus to continue interrogating these insidious forms of domination and control while offering practical solutions and identifying alternative

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[149] Sue Skipton, "Cuts, Privatization and Deregulations: A Look at the Impact of Some New Right Government Policies on Women" in *Atlantis: A Women's Studies Journal*, vol.21. no.2 (Spring 1997), 20.

[150] Kevin Taft and Gilliam Steward, generally.

[151] For a further discussion on this see: Marika Morris, Jane Robinson and Janet Simpson with Sherry Galey, Sandra Kirby, Lise Martin, and Martha Muzychka, The *Changing Nature of Home Care and Its Impact on Women's Vulnerability to Poverty* (Ottawa: Status of Women Canada, November 1999). For a detailed discussion on the situation in Québec see: Denyse Côté, Eric Gagnon, Claude Gilbert, Nancy Guberman, Francine Saillant, Nicole Thivierge, and Marielle Tremblay, *Who Will be Responsible for Providing Care? The Impact of the Shift to Ambulatory Care and of Social Economy Policies of Quebec Women* (Ottawa: Status of Women Canada, March 1998).

[152] Isabella Bakker, *Unpaid Work and Macroeconomics*, passim.

[153] Janine Brodie, "Restructuring and the New Citizenship," 131.

avenues of activism. The theoretical conjectures, are however, only effective if they can be adopted and employed in the political agenda of the women's movement and front-line activists. As such, this project will now explore how the women's movement is using scholarly models in fighting for women's full health potential and associated empowerment.

Practical Application: From Solidarity to Girl Power

In the past feminist agendas regularly included reproductive freedoms, freedom from violence, universal access to health care services and women-centered decision-making processes concerning health. Other health determinants, such as environmental factors and poverty, are also prominent issues continually being addressed by the women's movement. Through these struggles the women's movement has enjoyed many successes, with winning the battle to legalize abortions standing as one of the critical accomplishments.[154] Nonetheless, the contemporary discourses surrounding women's health issues have changed significantly in the past several decades. The current Canadian health care programs, which are masquerading as 'women-friendly' and 'community based,' are in reality being dictated by a neoliberal economic policy agenda that is instructed by neoconservative ideas. The necessity for an aggressive and solidaristic women's movement has never been more important, as government policies threaten to impair the precious gains women have accomplished and to generate new inequalities.

Political activism centered on women's health comes in a variety of different forms and has enjoyed several important successes in the recent past, such as the professionalization of midwifery in some provinces, the establishment of five women's health centers across Canada and the introduction of a feminist perspective in selected policy projects.[155] Evidence of the growing importance of women's health to the

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[154] For a full discussion see: Janine Brodie, Shelley A.M. Gavigan and Jane Jensen, *The Politics of Abortion* (Toronto: Oxford, 1992), generally,

[155] See: Farah M. Shroff, ed., *The New Midwifery: Reflections on Renaissance and Regulation* (Toronto: Women's Press, 1997), generally.

women's movement can also be located in the two global agreements ratified by the Canadian government: the Convention on the Elimination of All Forms of Discrimination Against Women and the Nairobi Forward-Looking Strategies for the Advancement of Women.[156] The statement of goals outlined in the two agreements were developed during the United Nations Decade for Women and were intended to oblige governments to initiate legislation that would guarantee women's full and equal participation in all spheres of economic, social and political life. Embroiled within the various demands was a concerted emphasis on women's health and access to health related decision-making processes. While the government's commitment has failed to come to fruition, the movement did succeed in starting a global conversation concerning women's health. However, these victories, while important, are only small battles in the larger struggles for women's health and its association with empowerment.

I would like to clarify that when I refer to the women's movement I am not referring to any particular structural organization. While the involvement of such organization as the NAC and the FFQ are paramount to the Canadian women's movement, the realities, and experiences of Canadian women are far too vast to categorize or represent in any systematic fashion. Although it is evident that health care is a concern for all women, the barriers, solutions and necessary services differ depending on context. Race, class, participation in the labour market, mental health, ability, age, sexual orientation, ethnicity, class, language, geography and the number of care giving responsibilities a women has, all need to be addressed and factored in the analysis. Thus by removing any sort of monolithic understanding of the women's movement, we are also removing any universal solution to establishing women's full health potential. As such, we are not looking for any stringent formula by which to calculate the health care needs of women, but rather a general recipe for empowerment in which the ingredients can be altered in the preparation and consumption of the programs and services.

A general overview of the women's movement's agenda for health can be approached through an exploration of the demands developed by the Canadian World

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[156] Deborah Stienstra and Barbara Roberts, *Strategies for the Year 2000: A Woman's Handbook* (Halifax: Fernwood Publishing, 1995), 1-3.

Women's March Committee. The Canadian delegation of the March identified women and health as the number one priority of the national feminist agenda. They identified the current problems as follows:

> Canadians know that the health care system is in crisis; 55% of Canadians polled rank it as the issue that should be politicians' number one concern. People are aware of emergency room overcrowding and closures, too few nurses, waiting lists for critical treatment, increasing drug costs, and increased private for-profit services. Hospital bed closures and discharges of mental health patients require community and home care programs that have not been established.
>
> Women are affected in many ways: nurses' working condition have deteriorated; contracting out and privatization of medical services have caused job loss and reduced quality of services. Discrimination and worsening work conditions have lead to increased stress and related health problems. Once again women are being asked to be caregivers, sometimes full-time, to provide in-hospital stays with family members and shoulder greater burdens of at-home care.[157]

The many challenges facing women and the achievement of their full health potential is overwhelming, as those forces seeking to disempower women are woven into a thick nexus of patriarchy and neoliberalism, which often appears impenetrable. Cementing our ideological beliefs in transformative political actions that create networks of activism and solidarity while recognizing that each woman's experience is situated in a particular context is paramount to the project of feminist praxis.

The neoliberal state has necessitated that the Canadian women's movement alter its agenda to some degree in order to address these new insidious forms of discrimination facing women. Thus, issues NAC highlights in its agenda include "the Canadian Health and Social transfer, and the call for a Canada Social Security Act; the devolution of federal responsibilities to the provinces, issues faced by Aboriginal women; immigrants, refugees and migrant workers; women with disabilities; lesbians; health and environment; violence against women; childcare; pensions; women and work; justice policy; housing policy; post-secondary education; and women's international solidarity and foreign policy."[158] However in the recent past the various actions taken by the NAC have been undermined or framed in a negative manner by the mainstream Canadian media.[159] For instance, NAC was not permitted "to appear before

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[157] Canadian Women's Match Committee, *Lobby Guide*.

[158] Nandita Sharma, *The National Action Committee on the Status of Women's Voters' Guide: A Women's Agenda for Social Justice* (Toronto: James Lorimer & Company, Publishers, 1997), ix.

the Standing Committee on Justice and Human Rights to present its brief on Bill C-23" (the hearings on same sex child benefits).[160] The 'NAC attack' is not overly surprising when one considered the manner in which the discourse of neoliberalism constructs such movements. As Janine Brodie explains, NAC's designation as "a special interest group . . . implies that its demands are not in the general interest."[161] Therefore, under the guise of the new order, NAC is viewed as not speaking for 'ordinary Canadians,' but as lobbying for rights that are in conflict with the individualist character of neoliberalism and the new formulation of citizenship.

The women's movement's health agenda is particularly concerned with the manner in which the recent health care crisis has affected women's workload. The increased burden on women's unpaid labour in caring for the sick, the working condition of nurses, and the reduction of quality care resulting from contracting out and privatization all feature predominately on NAC's agenda in the area of women's health.[162] In addition, NAC highlights the manner in which environmental containments and chemical toxins are increasingly impairing women's full health potential. Although NAC is calling on the government to restore full funding to the health care system, the organization is also prompting alternative avenues of activism associated with empowerment and holistic healing practices. The potency of NAC's demands for women's health care, have of course been undermined by the neoliberal agenda; however, I believe that the World Women's March has helped to reinstate NAC's prominence as a powerful vehicle of social change within Canadian society.[163]

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[159] Judy Rebick, "Anything But Racism" in *Canadian Forum* (September 1996), 96.

[160] Rachel Thompson, "Canadian Pulse" in *The Canadian Women's Health Network*, vol.3, no.1/2 (Spring 2000), 32.

[161] Janine Brodie, "Canadian Women, Changing State Forms, and Public Policy," 20.

[162] National Action Committee on the Status of Women, *Women's Global March 2000: Issue Sheet 1 – Women and Health Care*, [http://www.nac-cca.ca/march/infosht1_e.htm].

[163] The March was spearhead by the FFQ who along with NAC, organized a global rally represented by 130 different countries and over 2000 women's organizations. The campaign strategy was centered on two principle themes: ending poverty and eliminating violence against women. The Canadian organizations involved in the March were also conscientious of the "deep crisis in our culture and solidarity" which "bars productive dialogue between people of different cultures, denying us access to one of the greatest assets of humankind: our diversity." The World Women's March marked a watershed in Canadian history when on October 15 over 50,000 Canadian citizens marched to Ottawa and

While neoliberalism, the biomedical model, and neoconservative ideologies are paramount forces behind the reconfiguration of the Canadian health care system, the situation is worse for women, in that they use the Canadian health care system far more than men. Statistically, women live longer than men and experience more health related problems in the later years. Childbirth, menopause, depression and PMS are all considered gendered health problems that need to be medically managed by health care practitioners, further increasing women's contact with the health system.[164] The women's movement must therefore address a myriad of issues while struggling to survive after the aggressive defunding of the feminist agenda by the federal government. As the assumptions concerning the reengineering of the health care system are deeply entrenched into the public consciousness, feminists will have to confront oppositional claims about what constitutes health care delivery, they will need to critique the biomedical model and they will have to promote a more inclusive decision-making process in the production of health care policy.

Deinstitutionalization is another insidious aspect of the agenda promoted by the new governing philosophy concerning health care. For instance, the shift to community based care for senior citizens has not been accompanied by a reallocation of resources and as such, "the shift actually signifies the privatizing of costs and work associated with frailty and in old age."[165] Currently, familial structures and networks provide approximately 85-90% of care for the elderly, with only 10% coming from the public sector, suggesting that the government is retreating even further from its role of

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converged on Parliament Hill demanding rights for women. It was the largest demonstration in the history of the Canadian women's movement. In addition, approximately half a million Canadians signed postcards supporting the various initiatives of the March and demanded that women's rights be protected both nationally and internationally. See: Canadian Women's Match Committee, *World March of Women: Lobby Guide* (Summer 2000); Fédération des femmes du Québec, *World March of Women: Newsletter* vol.2, no.1 (July 1999), 1-2; Fédération des femmes du Québec, *World March of Women: Advocacy Guide to Women's World Demands* (July 1999).

[164] Baukje Miedema, Janet M. Stoppard & Vivienne Anderson, eds. *Women's Bodies, Women's Lives: Health, Well-Being and Body Image* (Toronto: Sumach Press, 2000), generally.

[165] Jane Aronson and Sheila M. Neysmith, "The Retreat of the State and Long Term Care Provision: Implications for Frail Elderly People, Unpaid Family Carers and Paid Home-Care Workers" in *Feminism, Political Economy and the State,* Pat Armstrong and M Patricia Connely, eds. (Toronto: Canadian Scholars Press, 1999), 91.

providing Canadian senior citizens universal health care.[166] The health of Canadians and the lack of government programs also determine the amount of care women must provide their families and extended family members. Therefore, the partition between the public and private spheres is also an important topic that the government fails to address in the context of health care.[167]

Undermining women's status as citizens, weakening the women's movement's ability to act on behalf of its constituents and policy framed in neoliberal language all coalesce to create a potent cocktail of neo-patriarchy. Consider the following example. The population in Canada is aging and by the year 2030 approximately 22% of Canadian citizens will be over the age of sixty-five.[168] Women live longer then men, however, half of all women over the age of sixty-five without a partner are considered 'poor' by Canadian standards.[169] There is a strong consensus among the Canadian public that the escalating costs of health care, combined with the aging population, will devastate the health care system. However, scholars argue that such claims are erroneous and that the system is in trouble due to "the intensity with which the system delivers treatment" to the elderly population and the failure of government support for homecare.[170] However, the government, employing the messages propagated by the media, uses these assumptions to justify reducing health care services by suggesting that the system cannot sustain the boom in an aging population. Accompanied with this governing philosophy is the neoconservative belief that the family is the appropriate

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[166] Peter Leonard and Barbara Nichols, *Gender, Aging and the State* (Montreal: Black Rose Books, 1994), 17.

[167] Sandra Harder argues that during the current period of restructuring all public policy should adopt a gendered lens, with particular attention paid to the manner in which policy impacts women's unpaid labour. See: Sandra Harder, *Economic Restructuring in Canada: Developing a Gender-Sensitive Analytical Framework* (Ottawa: Status of Women Canada, 1992).

[168] Ken Battle, "Seniors" in *In The Public Interest: The Value of the Public Service*, Steven Langdon, Judy Rebick and Rosemary Warskett, eds. (Ontario: Voyageur Publishing, 1994), 119.

[169] Monica Townson, *Reducing Poverty Among Older Women: The Potential of Retirement Incomes Policies* (Ottawa: Status of Women Canada, 2000), 3.

[170] National Forum on Health, *Health and Health Care Issues: Summaries of Papers Commissioned by the National Forum on Health* (Ottawa: Minster of Public Works and Government Services, 1997), 44.

locus for providing assistance and care to elderly people. The forces operating in this example are somewhat complex. In short, women's empowerment and women's health is being impaired by a plethora of factors stemming for the new governing philosophy requiring the Canadian women's movement to continue to struggle against 'traditional' forms of patriarchy while creating agenda that also respond to these newly minted forms of discrimination.

Praxis: Behind Door Number Two

In this chapter I have argued that feminist articulations of citizenship must be premised on a feminist praxis that empowers women and promotes the attainment of their full health potential. I suggested that the recent reconceptualization of the state-society relationship adopts phallocentric language, which identifies all citizens as being equal and thus equally responsible for their own health care needs. Those who have 'special' needs are cast as deviant and are not in alignment with the good citizen who is able to take care of herself. Neoliberalism and neoconservatism serve to further exacerbate the situations by adopting gender-neutral discourses to describe women-specific issues and adopting certain assumptions concerning the partition between the public and private sphere, which serve as a justification for offloading responsibility onto women.

My main point in this chapter has been to illustrate that although everything has changed including the style of governance, the meso-discourse, the citizenship regime, and the ideology, women's status in society remains the same – they are "second class citizens." In addition, dimensions of ethnicity, race, class, sexuality, age and socioeconomic status also continue to be powerful indicators of the rights of citizens in the Canadian polity. Although this is not meant to undermine the gains made by the women's movement, it should be highlighted that feminists have only begun to scratch the surface of oppression. Later in this thesis I will be exploring the fashion in which women's status as second-class citizens is reflected in policy outcome and women's absence from decision-making processes. In many respects, female policy makers who represent a so-called 'women-centered approach' to policy, reproduce these systems of

subordination by failing to recognize and conceptualize the various dimensions of race, class, gender and so on. In addition, I will be examining the manner in which gender-neutral language does not produce gender-neutral policy and how equity is not synonymous with equality.

In 1947, the World Health Organization defined health as a right that encompassed "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."[171] If the women's movement is going to be successful in validating universal health as a right that is entitled to all Canadian citizens, they will have to soundly reject the current approach that valorizes health as a commodity. The current period of state restructuring has furnished the women's movement with an ideal opportunity to illustrate why women's health care needs are not represented by the curative paradigm. In addition, the restructuring process offers the women's movement an opening to contest the adoption of a biomedical model based on fiscal restraint, professional authority and familial responsibility. Critiques from the past and insights from current feminist scholarship offer the women's movement a comprehensive platform upon which their agenda can be determined. Women's health is clearly a priority and the women's movement is by far the most promising vehicle by which to arrest the 21st century's version of patriarchy.

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[171] Quoted in: Pat Armstrong and Hugh Armstrong, *Wasting Away: The Undermining of Canadian Health Care* (Toronto: Oxford University Press, 1996), 14.

Chapter Three

Women's Health Care Policy: Writing Women In

Feminist health promotion empowerment then would begin with women's participation in the design of research, policy and programming. It would encourage collective action for reflection and action. It would guard against exploitation of women's time and labour and it would work towards structural change.

- *Margaret Denton et al.*[172]

Introduction

Feminist scholars and activists alike have always considered women's inclusion in the policy-making domain as imperative to the project of empowerment. Thus far I have discussed factors that impair women's enjoyment of their full health potential and impede women's empowerment. I have suggested that hyper-technology and its relationship to an advanced capitalist society posit a fictional characterization of femininity that fails to reveal the realties of women's lives and health care needs. I have argued that neoliberalism and its perennial companion, neoconservatism, create a hostile environment in which women's realization of full equality has been denied by a complex nexus of biases embedded in a certain conceptualization of citizenship. In this chapter, I begin to explore the fashion in which these dynamics play out in the arena of public policy. I argue that the state has failed to offer women the opportunity to partake in the decision-making process and I explore the demarcation of women's realities from the policy agendas dictated by a patriarchal state. In an attempt to locate a feminist variant of public policy I synthesize a variety of suggestions made by scholars, activists and researchers, which explodes the parochial formula employed by current policy entrepreneurs and challenges those structures that maintain male privilege. I contend that a changing of the political guard is necessary for empowering women and allowing them to achieve their full health potential.

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[172] Margaret Denton,Maroussia Hadjukowski-Ahmed, Mary O'Connor and Isik Urla Zeytinglu, *Women's Voices In Health Promotion* (Toronto: Canadian Scholars Press, 1999), 17.

This chapter examines the production and dissemination of women's health care policy and discusses how women's involvement in the decision-making process relates to empowerment. To start, I briefly trace the involvement of the women's movement, in its past attempts to change public policy production by gaining access to the realm of political decision-making. Next, I explore how a gendered lens provides an avenue of policy-making that begins to address women's differential location and relationship with the state. Third, I develop a framework that can be used as a guide to determine what constitutes 'women-friendly' policies on health care. Following this I discuss several of the federal government's commitments to gender analysis and illustrate that while some of their conjectures are simply erroneous, others serve to further exacerbate women's inequality and impede women's full health potential. To demonstrate the manner in which the lack of gendered analysis serves to marginalize and disempower women I explore the affects of colonialism, racism, sexism, hyper-technology and the patriarchal state on Aboriginal women's health. My main objective in this chapter is to illustrate that while public policy and the decision-making process may be utilized as a powerful tool for women's empowerment, the current organization of the state continues to construct barriers to women's full participation.[173]

Theory: Women's Health, Public Policy and the Canadian State

Engendering social policy and achieving universal access to state programs was central to the agenda of the second wave Canadian women's movement. During this era, feminists argued that state-initiated social and economic policy cultivated and advanced discriminatory and inequitable treatment of women. The dominant paradigm justified women's subordination through the use of various social conventions that "were a reflection of the gendered and hierarchical nature of society."[174] Inherent in the

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[173] I do not take the position that the state is fundamentally a male enterprise and as such not worthy of feminist attention. Instead, I believe that the current restructuring processes in Canada has afforded the women's movement with an ideal opportunity for contesting state structures and challenging the current policy agenda of the neoliberal state.

[174] Marjorie Griffin Cohen, "Social Policy and Social Services" in *Canadian Women's Issues Volume I: Strong Voices*, Ruth Roach Pierson, Marjorie Griffin Cohen, Paula Bourne and Philinda Masters (Toronto: James Lorimer & Company Publishers, 1993), 264.

women's movement's agenda for improving social policies and programs was the assumption that women's health was an important measurement of women's equality. As the second wave movement evolved, a consensus emerged, which suggested that feminist priorities concerning health should include freedom over their reproductive health, access to decision-making processes that affected women's health and that health care should be made universally available. Although their agenda concerning health was deeply influenced by the feminist scholarship of this era, several state-initiated factors also contributed to the consensus. The first such initiative, which marked a watershed in Canadian women's history, was The Royal Commission on the Status of Women. The Commission, which continues to stand as the largest women-centered state initiative ever taken by the Canadian government, was given a board mandate "to inquire into legislation, regulations and policies that concern or affect the rights of women."[175] The Commission provided Canadian women and the women's movement with the opportunity to engender public policy and contest the existing policies and programs that promoted inequality.[176] A second component contributing to the consensus originated with the 1961 Royal Commission on Health that decisively concluded that the state must implement a universal health care program, which promoted accountability, accessibility and equality.[177] These state initiatives provided the women's movement with a point of access, in which they could contest the manner in which policy was manufactured and demand equity in matters that affected women's health. A pragmatic liberal government recognized that the extraordinary pressures emanating from the women's movement could not be ignored, and as such, adopted new approaches to address women's demands, attempted to promote women's entry into government jobs, and invited the women's movement to partake in the decision-making process. As Sandra Burt punctuates, "the greatest amount of action undertaken

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[175] Quoted in Jane Ursel, *Private Live*, 283.

[176] Annis May Timpson, "Royal Commission as Sites of Resistance: Women's Challenges on Child Care in the Royal Commission on the Status of Women" in *International Journal of Canadian Studies*, vol. 20 (Fall 1999), 125-126.

[177] Ursel, *Private Live, Public Policy*, 272.

in the 1970s and 1980s to improve women's status was bureaucratic, and it facilitated a process of government redefinition of 'women's issues.'"[178]

Women's entry and involvement in the realm of political decision-making, while fundamental to the movement, was very limited in scope and therefore only produced marginal changes. While several different avenues of activism were followed the results varied. Nonetheless, in the early part of the 1980s the Canadian women's movement had a great deal to celebrate, considering their accomplishment in guaranteeing women's equality in the newly entrenched Charter of Rights and Freedoms. In addition, they had enjoyed some degree of success in obligating the state to use a gendered lens in the production and dissemination of public policy and programs. Moreover, the woman's movement had found allies in both female politicians and femocrats working within the bureaucratic structures of the Canadian polity.[179] As far as policy was concerned, several organizations, such as Status of Women Canada, were established to promote a women-centered perspective and illustrate the manner in which "women are quite differently related to the Canadian state than men," while recognizing "that women differently situated because of their majority/minority status (race, ethnicity, nation) or their personal status (sexual orientation, disability) may experience state policies, programs and benefits differently."[180] While, the adoption of a gendered lens gained currency among organizations employing a feminist perspective (which were few and far between) the adoption of a women-centered perspective did not permeate most state structures and

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[178] Sandra Burt, "The Changing Patterns of Public Policy" in *Changing Patterns: Women in Canada,* Sandra Burt, Lorraine Code and Lindsay Dorney, eds. (Toronto: McClelland & Stewart Inc., 1993), 225.

[179] For a full discussion on women's representation within party politics see: Linda Trimble, "Who's Represented? Gender and Diversity in the Alberta Legislature" in *Women and Political Representation in Canada* (Ottawa: University of Ottawa Press, 1998), 257-289; Jill Vickers, "Toward a Feminist Understanding of Representation" in *In the Presence of Women: Representation in Canadian Government,* Jane Arscott and Linda Trimble, eds. (Toronto: Harcourt BRACE & Company, Canada, 1997), 20-46; Lisa Young, "The Canadian Women's Movement and Political Parties, 1970-1993" in *Women and Political Representation in Canada* (Ottawa: University of Ottawa Press, 1998), 196-217.

[180] Jill Vickers, "Why Should Women Care About Federalism?" in *The State of the Federation,* Douglas Brown and Janet Hiebet, eds. (Canada: Queens Institute of Intergovernmental Relations, 1994), 135-36.

thus women's inclusion in the policy-making process was not advanced on a national scale by policy entrepreneurs and political actors.

During the mid-eighties the women's movement's focus veered from achieving equality within the Canadian state to addressing various forms of discrimination within the movement itself. The internal unrest was premised on two main areas of dissatisfaction. First, the women's movement experienced dissention among its constituents due to the failure of mainstream policy agendas to integrate equality seeking measures in policy plans. This criticism revolved around concerns that the movement had become too partisan and placed too much emphasis on state activities, which continued to reflect a patriarchal bias. Second and more importantly, the Canadian women's movement came under attack from women who felt marginalized by a predominately white middle-class movement. This criticism was far more fundamental as it brought to light the manner in which the "biases of the larger society are reflected in feminist practice – for example, in organizational structures, political processes, priority of issues, leadership and unequal distribution of power."[181] For those women who experienced racism, homophobia, ablism, ageism and classism as indelible aspects of their day-to-day lives, the agenda of the women's movement had little application for their emancipation. These marginalized women highlighted the manner in which the Canadian women's movement adopted a white, middle-class, heterosexual woman as the universal referent, which excluded the realities and experiences of a number of Canadian women. At the same time the government funding that had supported the NAC activism in the political sphere in the past was decreased. As has already been discussed, the neoliberal regime views the women's movement as a special interest group that does not represent the popular public consciousness.[182] This label allowed the government to justify funding cuts to the English Canadian women's movement's umbrella organization. Up until 1986 the NAC had received block funding from the federal government, which equated to approximately 60 percent of its budget, however, the NAC's government grants have been cut to project funding and the

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[181] Vijay Agnew, *Resisting Discrimination* (University of Toronto Press, 1996), 68.

[182] Alexandra Dobrowolsky, "Of 'Special Interest': Interest, Identity and Feminist Constitutional Activism in Canada" in *Canadian Journal of Political Science,* XXXI: 4 (December, 1998), 709.

organization publicly stated in 1999 that it "was facing the prospect of closure."[183] Add on to these problems the backlash the women's movement was experiencing from the media and the women's movement entered a period of full crisis.[184]

In the context of health care, the English Canadian women's movement, which was at this time synonymous with the NAC, identified three primary areas of concentration that would guide the agenda for health care: censorship of pornographic movies, access to abortion and the occupational health of women.[185] Officially written into the agenda in 1984 at a national women's conference, these foci were framed in terms of bodily autonomy and protection from an intrusive medical establishment. Therefore the policy agenda, in terms of health, was to ensure women greater access to those decision-making processes that concerned their bodies. In the same year, however, under the new Progressive Conservative government of Brain Mulroney, a reversal in the approach to public policy-making began to gain currency. The Mulroney government quickly adopted a similar approach to the British Prime Minister Margaret Thatcher, who "was committed to reducing the size of government, including its welfare dimension."[186] The ascendancy of the neoliberal state and the global diffusion of Thatcherism ushered in a new mentality for both policy makers and political actors. Mulroney's reorganization of the state introduced a whole new matrix of problems for the women's movement and feminist scholars. Despite the fact that women's input

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[183] Sandra Burt, "Canadian Women's Movements: Revisiting Historical Patterns and Considering Present Developments," 409.

[184] The manner in which the media frames the women's movement is often cemented into the minds of the Canadian public. In the last decade, the movement has been literally shutout of media coverage unless there is some sort of internal conflict in the movement. See: Jenn Goddu, " 'Powerless, Public-Spirited Women,' 'Angry Feminists,' and 'The Muffin Lobby': Newspaper and Magazine Coverage of Three National Women's Groups from 1980-1995" in *Canadian Journal of Communications,* vol.24. (1999), 105-126 and Judy Rebick, and Kiké Roach, *Politically Speaking* (Toronto: Douglas & McIntyre, 1999).

[185] Pornography is conceptualized as a health care issue as it promotes violence against women, it impacts the psychological health of women and it impairs women's freedom to control their bodies. It is however puzzling why pornography was included in NAC's agenda but prostitution was not. See: Sandra Burt, "Gender and Public Policy: Making Some Difference Ottawa," 89.

[186] Sylvia Bashevkin, *Women on the Defensive: Living Through Conservative Times* (Toronto: University of Toronto Press, 1998), 3. See also: Eric J. Evans, *Thatcher and Thatcherism* (London and New York: Routledge, 1997).

gained legitimacy during the previous era, there was the heightened recognition that the state continued to be "a form of public patriarchy as well as a source of women's empowerment."[187] While a strong androcentric bias had continued to infiltrate public policies during the 70s and 80s, the introduction of the neoliberal policy formula manufactured a whole host of new structural barriers to women's full and equal participation. The new style of policy production that is associated with neoliberalism is far more insidious than in the past, as social policies are now premised on "a gender-neutral human resource model, which sees joblessness and poverty as an individual rather than [a] structural problem."[188] Thus, the only way to identify women's differential location in the new neoliberal state is to continue to promote a gendered analysis of policy initiatives. In addition, health care policy can no longer be viewed as a mutually exclusive category, because as feminist research has clearly illustrated, it is inexorably linked with socioeconomic factors, race, ethnicity, sexual orientation, age, class, ability, and geographic location.

The integration of a gendered analysis in the production of public policy will fundamentally enhance the ability of government organizations to deliver services and programs that address the realties of women's lives and allow for the articulation of various feminist strategies. A gender-based analysis of health care will provide policy-makers with "the basis for designing sharp policy instruments in areas where they may be rather blunt."[189] The need for gendered analysis and an appropriate evaluation framework is paramount in addressing the health of Canadian women in that

> Health policies and practices for the most part are not planned, implemented and evaluated to take into account the differential impact on women and men, and on different groups of women. A gender-specific program evaluation framework must incorporate recognition of issues such as the ways in which women experience their health concerns, how immigrant women and other

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[187] Janine Brodie, "Shifting the Boundaries: Gender and the Politics of Restructuring" in *The Strategic Silence: Gender and Economic Policy*, Isabella Bakker, ed. (London: Zed Books, 1994), 54.

[188] Bakker and Brodie, *The New Health and Social Transfer (CHST)*, 8.

[189] Jane Friesn, "Gender Equality Indicators and Gender-Based Analysis" in *Gender Equality Indicators: Public Concerns and Public Polices.* Health Canada, Human Resources Development Canada, Statistics Canada and Status of Women Canada. Proceeding of a Symposium held at Statistic Canada March 26.and 27, 1998. (Ottawa: Status of Women Canada, 1999), 27.

groups construct their identities and the resultant impact on health, and how women-centered health services can best be delivered to meet women's needs.[190]

An overview of the recent literature suggests that policy construction and evaluation must follow a certain criteria in order to address the varied circumstances of women's health and their accessibility to services. In addition, these criteria must necessarily be incorporated at all stages in the development of policy and the implementation of services. Currently, gender is not considered a key determinant of health and as such is not viewed as a core tenet in the creation of health care policy. Under the rubric of neoliberalism, the medical establishment has adopted a new model of studying public health referred to as the 'population health' approach. Population health, which is the main research instrument used to direct policy initiatives, recognizes five main determinants of health: socioeconomic factors, healthy childhood development, physical environment, personal health practices and biology and genetic endowments.[191] Statistical data is collected concerning the usage of health care services and programs, the number of individuals diagnosed with an illness, the number of cases reported of particular illnesses and the amount of pharmaceutical medication being used by Canadian citizens. These numbers are then percolated through an efficiency filter to determine which health care services are cost effective. Through the phallocentric discourse adopted to develop policy and measure quality of care, women become subsumed under the gender-neutral language of the 'general' population.

Feminist scholars and women's health care activists have offered a number of alternatives to the manner in which health care policy is currently being produced. While some of their recommendations and themes are perennial and focus on all women, others are more specific, depending on the group of women that the policy is directed at. An aggregate of these suggestions and recommendations produces a feminist centered framework that requires policy entrepreneurs and government actors

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[190] Joan McLaren, *Evaluating Programs for Women: A Gender-Specific Framework* (Winnipeg: Prairie Women's Health: Centre of Excellence, 1998), 2.

[191] Health Canada, *Towards a Healthy Future: Second Report on the Health of Canadians,* prepared by the Federal, Provincial, and Territorial Advisory Committee on Population Health for the Meeting of the First Ministers of Health, Charlottetown, PEI, September 1999 (Ottawa: Minster of Public Works and Government Services of Canada, 1999), generally.

to address a number of explicitly women-specific realties and experiences.[192] The framework obliges policy-makers to answer specific questions, include women's voices and speak to the manner in which women are situated in relation to the state. A general blueprint for the creation of gender sensitive policy would address the following issues and ask the following questions:

- Is women's health treated as a priority?
- Does the policy and/or ensuing programs recognize the context and determinants of women's health?
- What approaches do policy-makers use in constructing services and programs for women's health – allopathic or holistic?
- Is there attention paid to the diversity among women's health care needs and barriers to participation?
- Are women involved in the decision-making process and the implementation of services?
- Is the production of new policy accompanied by a system of social support?
- How much women's labour, both paid and unpaid, is affected by the implementation of a new program or the erosion of an existing service?
- Have socioeconomic factors been taken into account in the production of new policy?
- Is the policy accessible to its targeted population both geographically and linguistically?
- Have women's organizations partaken in the consultation process?

Currently, the extent of the failure to address these factors and questions in the creation of public policy in Canada is horrendous. Not only is gender not considered a key determinant of health, despite all the evidence to the contrary, the enormous work done

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[192] See: Annette Browne, Jo-Anne Fiske and Geraldine Thomas, *First Nations Women's Encountered with the Mainstream Health Care Services and Systems* (Vancouver: BC Centre of Excellence for Women's Health, 2000); Tammy Horne, Lissa Donner and Wilfreda E. Thurston, *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress* (Winnipeg: Prairie Women's Health: Centre of Excellence, 1998); B.L. Janzen, *Women, Gender and Health: A Review of the Recent Literature* (Winnipeg: Prairie Women's Health: Centre of Excellence, 1998); Shirley Masuda, *Women with Disabilities: We Know What We Need to be Healthy* (Vancouver: BC Centre of Excellence for Women's Health, 2000); McLaren, *Evaluating Programs for Women.*

by the women's movement in the past is being jeopardized by the new hegemonic paradigm which views health care as a private matter, in which each individual citizen is expected to take care of herself and her family. Therefore, women's oppression is perpetuated and is manifested in a bureaucracy that continues to universalize male experiences, and in the case of health care male diseases. In order to understand women's health in context, gender must be recognized as a key determinant and women's socioeconomic status must be addressed as a separate category from men.

In 1995 the federal government, in conjunction with the Status of Women Canada, released a report titled *Setting the Stage for the Next Century: The Federal Plan for Gender Equality.* In this report the government makes a number of promises concerning the manner in which a gendered lens would be adopted in the production of public policy. In addition, the government pledged to incorporate more women into the decision-making process. *Setting the Stage* describes gender-based analysis as "intrinsic to quality policy analysis" and defines gender based analysis as follows:

> Gender analysis is based on the standpoint that policy cannot be separated from the social context and that social issues are an integral part of economic issues. Social impact analysis, including gender analysis, is not just an add-on, to be considered after costs and benefits have been assessed, but an integral part of good policy analysis.[193]

According to the federal government, gendered analysis is necessary for accomplishing gender equality and one of the main priorities for action is the federal government's commitment to "ensuring that gender is widely understood and used as a fundamental variable in health policy development, research and evaluation."[194] The government suggests that its primary objective is to deliver high quality care to both men and women by promoting gender based research and analysis. *Setting the Stage* emphasizes that:

> Virtually all health systems across Canada are undergoing significant restructuring and realignment. These changes have a profound effect on Canadians. The potential exists for health system reform and renewal to have a *favorable* impact on women as more emphasis is placed on greater responsiveness to patient needs, deinstitutionalization, the advent of new care givers such as midwives and nurse-practitioners, the use of evidence-based outcomes, support

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[193] Canada, *Setting the Stage for the Next Century: The Federal Plan for Gender Equality* (Ottawa: Status of Women Canada, August 1995), 18.

[194] Ibid., 34

> for more citizen responsibilities for personal health and health-system decisions making, and achieving a better balance between health care and health promotion and prevention measures.[195]

What the federal government identifies as opportunity structures are, in reality, further barriers to women's participation in the decision-making process and an affirmation that the government will continue to offload health care responsibility into the private sphere. The above statement directly contradicts the government's promise concerning a gender-based focus to support and promote gender-based policy analysis.

There are a plethora of examples that illustrate the fashion in which the government's statement is contradictory. For instance, applying the population approach to entire segments of society produces 'evidence-based outcomes' and cultivates policy based on certain social structures that impact the health of a population.[196] The approach, however, is framed by neoliberalism and as such adopts gender-neutral language to explain women-specific health problems. Another problematic statement in the report is the promotion of increased 'citizen responsibilities for personal health,' which is directly associated with the reconceptualization of citizenship in the neoliberal era. This approach to health shifts the responsibility to the individual by suggesting that as good citizens, individuals should keep themselves healthy.

While a government's failure to live up to its promises is certainly not a novel phenomenon, what is most important for the purposes of this thesis is the manner in which the government is able to frame its commitments as emancipatory when, in fact, these initiatives are designed to further exacerbate women's oppression. The ability of the federal government to regulate its use of a gendered lens in the production of public policy is lost in the devolution of health care services from the federal level, to the provincial governments and then down to regionalized health care boards. While regional boards may list women's health as a priority, an explicitly gendered analysis increases the cost of research and is thus in conflict with the funding restraints imposed by the provincial governments on regional health bodies. In addition, the lack of female-centered research is primarily caused by "a lack of value placed on woman's

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[195] Emphasis added. Ibid., 35.

[196] Monica Townson, *Health and Wealth: How Fiscal and Economic Factors Affect Our Well Being* (Ottawa: Canadian Centre for Policy Alternatives, 1999), 12.

health in general, and therefore, on gender analysis in particular as legitimate areas of concern."[197] Therefore, while the federal government can continually renew its commitment to a gendered focus, the new methodology for funding weakens their ability to impose universal standards on provincial and regional health bodies, which allows for the backdoor entry of such insidious policies as the one introduced by the Klein government.[198] While Ralph Klein claims to be simply experimenting with privatization, once Pandora's box is opened there is no turning back.[199]

In 1997, the government commissioned a national forum to inquire into the health care system in Canada and to determine which avenues should be taken to produce effective public policy on health. The Forum's mandate "was to engage the public and health stakeholders in a dialogue, the results of which, along with their own research and study, would guide in charting a course for the future of health and health care in Canada."[200] The Prime Minster chaired the Forum and the Minster of Health was the Vice-Chair.[201] The final report from the National Forum on Health strongly recommended that gender be adopted as a key determinant of health. The report argues that "this addition would help planners, policy makers and programmers avoid inappropriate or inaccurate generalization about 'people' when gender differences are significant for health; it would ensure that these differences are taken into account."[202] According to the Forum, incorporating a gendered lens would allow policy engineers to recognize that women's health differs significantly from men's, as do women's

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[197] Horne, Donner and Thurston, *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, 36.

[198] Taft and Steward, *Clear Answers: the Economics and Politics of For-Profit Medicine*, generally.

[199] By allowing for-profit care and the entry of American medical conglomerates into Canadian markets Klein has put the entire country at risk of health care privatization. Under the rules of NAFTA, "a foreign for-profit health care company could charge that the Alberta law had an impact on federal law (the Canadian Health Act) and that the whole country was now open to for-profit hospitals. See: Kemlin Nembhard and Rachel Thompson, "Getting to the Heart of the Private Hospital Debate" in *Canadian Women's Health Network* (Spring 2000), 17.

[200] Health Canada, *Canada's Health System: Fact Sheet* (Ottawa: Health Canada, 2000).

[201] Ibid.

[202] National Forum on Health, *Canada Health Action: Building on the Legacy. Final Report of the National Forum on Health* (Ottawa: Minster of Public Works and Government Services, 1997), 5:3.

experiences with the medical establishment. These recommendations, however, were not taken into account and gender has not been added to the list of key health determinants. In fact, several years later, the health care report prepared for the First Ministers' meeting featured only one line concerning this topic: "Enhanced analysis of the effect of gender, culture, age/stage of development and socioeconomic status on measures of health is needed."[203]

Through it all, a disheartened and disgruntled women's movement marches on. While the women's movement has been successful in building coalitions with other social activists, the serious decline in political resources has impaired its ability to act as a central organizing agent. This is not to suggest, however, that the war is over – the women's movement just needs new weapons. Feminist scholars need to continue to reveal and name the policies that act to oppress women, and identify the fashion in which phallocentric discourses are operating in tandem with neoliberalism as an active ideological force. The efforts and energy of the second wave women's movement in Canada precipitated a heightened awareness of the gendered dimensions of the production and dissemination of public policy, which culminated into some degree of recognition by policy-makers that the existing structures were predicated on androcentric biases. The recognition that women's health is paramount to women's equality, however, remains unattained.

III. Practical Applications: Triple Jeopardy

Theoretical explanations concerning citizenship, neoliberalism and neoconservatism provide feminists with an analytic framework that may be used to develop models that explain women status within the Canadian state, however, only through the practical application of these theoretical speculations are we able to specify how policy agendas that exclude women's voices serve to impair their full health potential and appropriate women's agency. This portion of the chapter will examine the health and empowerment of Aboriginal women in the contemporary Canadian state. To

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[203] Health Canada, *Towards a Healthy Future*, 177.

begin, I briefly trace the evolution of Aboriginal health care policy in the Canadian state. Second, I consider how sexism, colonialism and racism have been combined into a hazardous cocktail that damages Aboriginal women's empowerment. Third, I provide evidence that illustrates the manner in which gender is a key determinant of health and must be incorporated into any analysis that seeks to establish equality. The main objective of this section is to illustrate the manner in which Aboriginal women are faced with 'triple jeopardy' as women, as Aboriginals and as visible minorities.[204] Prior to beginning, several points must be clarified. First, Aboriginal women do not constitute a homogenous group and do not all share in similar experiences and realities. Second, the Aboriginal women's movement is not tantamount to the Canadian feminist movement. While there are a number of Aboriginal scholars who adopt explicitly feminist approaches, there are also Aboriginal women who reject the theoretical conjectures associated with feminism.[205] The Aboriginal women's movement is, however, a women's movement fighting to destabilize current power structures and residual forms of discrimination and does juxtapose a number of feminist conjectures with cultural analysis, anti-racist critiques and so forth.

In 1998, the federal government released a report that responded to the recommendations made by the Royal Commission on Aboriginal People, which was designed to direct the future partnership between First Nations and the federal government. The report, titled *Gathering Strength: Canada's Aboriginal Action Plan,* had four main objectives: a renewed partnership between Aboriginal people and the federal government, strengthening the role of Aboriginal governance in First Nations

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[204] Lilianne Ernestine Krosenbrink-Gelissen, "The Native Women's Association of Canada" in James S. Friederes with Lilianne Ernestine Krosenbrink-Gelissen, *Aboriginal Peoples in Canada: Contemporary Conflicts,* 5th ed. (Ontario: Prentice Hall Allyn and Bacon Canada, 1998), 299.

[205] Aboriginal feminism is well represented throughout this thesis, however for explicit examples see: Kathleen Jamieson, *Indian Women and the Law in Canada: Citizens Minus* (Ottawa: Minister of Supply and Services, 1978); Emma LaRocque, "Re-examining Culturally Appropriate Models in Criminal Justice Applications" in *Aboriginal and Treaty Rights in Canada: Essays on Law, Equality, and Respect for Difference*, Michael Ash, ed. (Vancouver: UBC Press, 1997), 75-96; Carole Leclair, "Métis Wisdom: Learning and Teaching Across the Cultures" in *Atlantis: A Women's Studies Journal,* vol. 22, no.2 (Spring 1998), 123-126. For a contrasting view see: Lee Maracle, *I Am Woman: A Native Perspective on Sociology and Feminism* (Vancouver: Press Gang Publishers, 1997); Donna Kahenrakwas Goodleaf, "Under Military Occupation: Indigenous Women, State Violence and Community Resistance" in *And Still We Rise: Feminist Political Mobilizing in Contemporary Canada,* Linda Carty, ed. (Ontario: Women's Press, 1997), 225-242.

communities, establishing a new economic relationship between Aboriginal nations and the state, and a government commitment to promote 'strong' Aboriginal communities and economies.[206] Throughout the report, the government reaffirmed its pledge to seek equity between Aboriginal women and men through the use of gender-based analysis and women's inclusion in the decision-making process.

Women's involvement in the production of policy is paramount to developing services and programs that address the specific realties and experiences of women's needs. If women are to be included in the new partnership between Aboriginal communities and the government, there must be a concerted effort on the part of both government and male-dominated Aboriginal organizations to provide women with the space to have their voices heard. Inclusion and equality, however, have not been emblematic of the past interactions of Aboriginal women with the state, nor have these goals figured predominately among male-dominated Aboriginal organizations. While there are numerous topics that illustrate these inequitable relationships, the policy-making process surrounding Aboriginal women's health and well-being is particularly telling as it reveals the complex interactions of patriarchy, colonialism, the neoliberal agenda, hyper-technology and capitalism.

The state's failure to incorporate gender into the creation of health care policy affects Aboriginal women's full health potential in a myriad of fashions, by alienating them from decision-making processes, undermining traditional medical practices and perpetuating androcentric biases. Each one of these factors serves to marginalize Aboriginal women to the peripheries of health care design and implementation. Aboriginal women's empowerment has been profoundly influenced by sexism, colonialism and racism, which in turn produces both structural and cultural barriers that impede Aboriginal women's enjoyment of their full health potential. The situation is further exacerbated by the dichotomy between traditional community medical practices and the westernized valorization of biotechnology. This process is circular, in that the structural and cultural barriers that are created by sexism, colonialism and racism

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[206] Indian Affairs and Northern Development, *Gathering Strength: Canada's Aboriginal Action Plan* (Ottawa: Minister of Public Works and Government Services Canada, 1997).

perpetually reinforce negative interactions between Aboriginal women and mainstream health care providers.

All Canadian women face some degree of sexism in their day-to-day life. While Aboriginal women face the same forms of discrimination, their situation is further exacerbated by a colonial past and modern manifestations of racism. For over a century, Canada's Aboriginal women have been subjected to discriminatory legislation that has denied them the opportunity to authenticate socially, politically or economically. The *Indian Act*, which is the alpha and omega of day-to-day lives in First Nations communities, has always been an assimilative mechanism designed to absorb Aboriginal peoples into the dominant culture. However, for those women who are not classed as 'status' Indians, the *Indian Act* constructs a barrier denying them access to their culture, their land and other ancestral rights.[207] The *Indian Act*'s calculation of status (vis-à-vis patrilineally) reflected European assumptions concerning women's traditional roles in the public arena.[208] As Aboriginal peoples were increasingly defined in "racially exclusive terms as a homogeneous collectivity" their cultural and linguistic identities were eroded and their traditional forms of governance obliterated.[209]

Public policy in the Canadian state uses a linear approach in identifying, manufacturing, and delivering programs and services to the citizenry. Traditionally, policy initiatives concerning First Nations followed this process and tended to produce policy that failed to address the plethora of factors influencing the health status of Aboriginal peoples. The dominant strategy of the past was to treat Aboriginal peoples as wards of the state with the eventual goal of assimilation. This agenda produced a number of discriminatory and paternalist policies and programs that perpetuated the health inequalities between Aboriginal peoples and their Euro-Canadian cohorts. In

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[207] Caroline Lachapelle, "Beyond Barriers: Native Women and the Women's Movement" in *Still Ain't Satisfied: Canadian Feminism Today*, Maureen Fitzgerald, Connie Guberman and Margie Wolfe, eds. (Toronto: The Women's Press, 1982), 259.

[208] Joyce Green, "Sexual Equality and Indian Government: An Analysis of Bill C-31 Amendments to the Indian Act" in *Native Studies Review*, vol.1, no.2 (1985), 83.

[209] Vic Satzewich and Li Zong, "Social Control and the Historical Construction of Race" in *Social Control in Canada: Issues in the Social Construction of Deviance*, Bernard Schissel and Linda Mahood, eds. (Toronto: Oxford University Press, 1996) 277.

contemporary Canada there has been a decided shift away from creating Aboriginal policy that fails to take into account the demands and desires of First Nations communities. As such, the federal government is currently in the process of transferring responsibility and control of health care services to First Nations. This transfer marks a profound change in the attitudes of the state concerning Aboriginal health care, as it seeks to provide First Nations communities with greater control over the production of policy and delivery of services, which is paramount to the project of self-government. The process by which the government is transferring authority however, is extremely complex and promises to be very time consuming. Nonetheless, the course of action has begun and an increasing number of Aboriginal communities are enjoying greater autonomy over community health care. Prior to discussing the transfer it is necessary to understand the evolution of Aboriginal policy in the Canadian state.

The British Indian Department, established in 1755, was the first crown department in North America to be given a mandate to communicate and establish trading relations with the indigenous population; however, in 1860 the British Crown transferred all responsibility for Aboriginal peoples to the dominion government, which marked the beginning of Indian administration in Canada.[210] At the time of Confederation, the *1867 Constitution Act* provided the Canadian state with legislative authority over all Aboriginal peoples and their lands, with a 1939 Supreme Court decision extending the government's control to the Inuit.[211] In 1960, the government established the Department of Indian Affairs and Northern Development (DIAND), which was responsible for all Aboriginal policies, programs and objectives. The *Indian Act* was the main instrument used by the government to determine policy concerning Aboriginal peoples.

The *1867 Constitution Act* and the *1876 Indian Act* gave the federal government jurisdiction over Aboriginal peoples living on reserve lands. Those Aboriginal peoples who were stripped of their status were considered provincial constituents who had no claims to federal programs. The interpretation of the federal government's

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[210] James S. Frideres, *Aboriginal People in Canada: Contemporary Conflicts*. 5th ed. (Scarborough: Prentice Hall Allyn and Bacon Canada, 1998), 196.

[211] Ibid.

responsibility for providing Aboriginal health care has been a much-contested terrain. The lacuna between the agreements Aboriginal leaders originally negotiated and the government's understanding of its obligations has resulted in many conflicts between the state and First Nations. There exists, however, several clauses, which indicate that Aboriginal health care is a fiduciary responsibility of the Canadian government. One such example arises from a commitment in Treaty 6 that promised the Plains Cree a medicine chest. Sharon Venne suggests that the "chiefs and Headmen [of the Plains Cree] successfully negotiated universal health care for all Indigenous peoples" because they "knew about the diseases of non-Indigenous peoples that were destroying their populations and needed to have the non-Indigenous medicine to fight them."[212] Legislative authority concerning Aboriginal health is also located in paragraph 73 of the *Indian Act*, which "refers to the containment of on-reserve epidemics, provisions of medical services, compulsory hospitalization for infectious diseases, and provisions of sanitary conditions on reserves."[213] For the most part, Aboriginal health care was ignored until the 1930s when the tuberculosis epidemic ravaging the Indigenous population threatened to spread to the Euro-Canada communities. In an attempt to contain the disease, the government established regional hospitals, public health centers and primary clinics in Aboriginal communities, forcing First Nations people to use the various institutions and practices of western medicine. During the period between the 1930s and the introduction of the government's White Papers, there was very little change in regards to the delivery of Aboriginal health, practitioners remained Euro-Canadian and the authoritarian agenda of western medicine dominated both the policy arenas and the delivery of services. However, following the reaction of Aboriginal leaders to the 1969 White Papers, the manner in which the federal government developed policy concerning Aboriginal health and the delivery of services was altered dramatically, culminating in the introduction of the 1979 Indian Health Policy.

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[212] Sharon Venne, "Understanding Treaty 6: An Indigenous Perspective" in *Aboriginal and Treaty Rights in Canada: Essays on Law, Equality and Respect for Difference*, Michael Asch, ed. (Vancouver: UBC Press, 1997), 194.

[213] John O'Neil, Yvon Allard and Brian Postl, "Community Healing and Aboriginal Self-Government" in *Aboriginal Self-Government in Canada*, John H. Hylton, ed. Forward by Phil Fontaine (Saskatoon: Purich Publishing Ltd., 1999), 135.

Traditionally, the creation of policy concerning First Nations communities was an exclusionary process that failed to incorporate Aboriginal perspectives into the agenda. According to James Frideres, this has been a perennial problem as "[t]hose who determine Indian and Inuit Affairs Program policies seldom, if ever, have direct experience with Aboriginal issues. Policies are developed by Indian and Inuit Affairs program bureaucrats" which are then "amended by bureaucrats from other government areas that are likely to be affected by the policies."[214] However, in recent years the relationship between Aboriginal peoples and the Canadian government has changed quite dramatically. Some commentators contend that Aboriginal peoples have acquired a great deal of political capital in the last several decades, which has pushed policies concerning First Nations to the center of the federal agenda. Abele, Graham and Maslove suggest that new initiatives "represent a major shift in [the] underlying philosophy, practice, and emphasis" of both Ottawa and First Nations.[215] They argue that these advancements are rooted in three main developments that stem from constitutional conferences, treaty negotiations and community activities. The first development is associated with the manner in which the governing philosophy of state institutions has evolved and now consults First Nations prior to creating Aboriginal policy. The second development is associated with the enhanced ability of First Nations to undertake political advocacy in constitutional negotiations and on the federal political stage. The third development stems from "the cross-fertilization between the domains of high politics and policy and the reality and aspirations of people 'on the ground.'"[216] In part, the RCAP and the associated recommendations motivated this alteration in the policy agenda; however the establishment of a territorial government in Nunavut and

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[214] Ibid., 219

[215] Frances Abele, Katherine A. Graham and Allan M. Maslove, "Negotiating Canada: Changes in Aboriginal Policy Over the Last Thirty Years" in Frances Abele, ed. *How Ottawa Spends 1991-1992:The Politics of Fragmentation* (Ottawa: Carleton University Press, 1991), 252.

[216] Ibid., 256.

the 1998 Nisga'a Treaty also played important roles in the new policy dynamics.[217] Despite the new approaches to health care policy for Aboriginal peoples and the new delivery services being implemented in First Nations communities, the degree to which the policy dynamic is evident in the context of Aboriginal women's health is questionable. Indeed, Aboriginal women's health remains vulnerable to structural patriarchy, capitalist motives and systemic racism.

Policy concerning Aboriginal health is the responsibility of the Medical Services Branch (MSB) and DIAND. Originally, DIAND was responsible for all Aboriginal programs, services, and policy; however, health services were later transferred to the MSB, which became responsible for hospitals, non-insured benefits, practitioners, programs, preventative measures, and other health care centers. DIAND remained in control of all other aspects of services and programs for Aboriginal peoples, including those matters that directly impact the health status of First Nations, such as housing, water, sewage systems and social assistance.[218] During the mid-sixties, the agenda concerning Aboriginal policy switched from one of assimilation to one of devolution. The new policy program emerged in response to First Nations' demands for greater autonomy and a return to traditional lifestyles. An administrative shift of DAIND agencies from Ottawa to regional and district offices accompanied the devolution of power from the federal government to First Nations. This process of decentralization allowed First Nations to increase their level of participation in the policy making process and to identify which services and programs would best address the needs of a specific community.[219] The transfer of health care services and programs from the federal government to First Nations communities did not begin until the introduction of the 1979 Indian Health Policy. The Indian Health Policy was in essence a template,

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[217] Frances Abele, "The Importance of Consent: Indigenous Peoples' Politics in Canada" in *Canadian Politics,* 3rd ed. James Bickerton and Alain-G Gagnon, eds. (Ontario: Broadview Press, 1999), 452.

[218] Alma Favel-King, "The Treaty Right to Health" in *The Path to Healing: Report of the National Roundtable on Aboriginal Health and Social Issues: Discussion Papers* (Ottawa: Communications Group Publishers, 1994), 121.

[219] Frideres, *Aboriginal People in Canada,* 222.

which outlined the various methods of transfer by which First Nations communities could assume control over health care services.

The 1979 Indian Health Policy was premised on three main principles. The first was concerned with "community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being."[220] Second, the policy recognized the necessity of strengthening the relationship between Aboriginal peoples and the federal government by encouraging a greater degree of participation in the manufacturing of policy and the delivery of services. The third principle recognized that the combined services and responsibilities of different levels of government must be taken into account when designing policy for First Nations health. The federal policy states that "the federal roles of this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment."[221] The provincial roles consist of providing services to diagnose and treat acute and chronic illness and to provide rehabilitation services to individuals suffering from injuries. Finally, First Nations' roles will consist of health promotion and responsibilities for adapting health services that are designed to address the specific needs of their community. The government claims its objective for "Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves."[222] The 1979 Indian Health Policy marks a decided shift from the original strategy of the MSB, which developed policy, designed programs and implemented services without any input from Aboriginal peoples. The new long-term goal of the MSB is to establish a "renewed relationship with First Nations that is based on the transfer of direct health services and a refocused federal role, and that seeks to improve the health status of First Nations and

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[220] Health Canada, *Indian Health Policy 1979* (Ottawa: Health Canada, 2000), [http://www.hc-sc.gc.ca/msb/pptsp/hfa/publications/poli79_e.htm].

[221] Ibid.

[222] Ibid.

Inuit."[223] The new goal was accompanied with a renaming of the MSB to the First Nations and Inuit Health Branch (FNIHB).

The federal government has designed a number of short-term strategies by which First Nations communities will assume greater control and autonomy over health care services.[224] While the long-term goal remains the complete transfer of health resources and responsibilities to Aboriginal governments, the interim objective is aimed at providing Aboriginal communities with the health care resources necessary to develop policy and establish sustainable First Nations health delivery systems. The FNIHB provides guidelines, funding and educational programs to assist First Nations in transferring health care responsibility to the community level. In addition, the department, in partnership with the Assembly of First Nations (AFN), has developed an agenda that identifies twenty specific initiatives regarding the transfer of health care services, priority projects and a transitional transfer framework.[225] Five specific

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[223] Health Canada, *Medical Services Branch* (Ottawa: Health Canada, 2000), [http://www.hc-sc.gc.ca/msb/msb_e.htm#mission].

[224] The first of the five strategies, and the one that provides the least degree of control, is the use of contribution agreements, which governs the management of certain health care programs. The second strategy First Nations may chose to implement in order to gain control over health care services is being referred to as integrated agreements, in which the community would agree to establish a health management structure and to enter into a planning process that would result in the completion of a workplan. The third approach flows from the first two strategies and typically occurs only after communities have successfully implemented a system of contribution agreements and a system of integrated agreements. Following various negotiations between FNIHB, DIAND and the First Nations community, a single funding mechanism is employed regarding programs, policy and health care delivery services. This approach allocates Aboriginal people far greater administrative control over the delivery of health services and allows unspent money to be retained by the band. Single funding agreements are designed as a preparatory mechanism that will assist First Nations in negotiations during the joint agreement between the community and the federal government, which is the final step towards full control of Aboriginal health care through self-government. The federal government has also offered an alternative approach to the three-step process through 'health transfers' from Ottawa to First Nations governments. See: Medical Services Branch, *First Nations and Inuit Control 1999-2000* (Ottawa: Minster of Public Works and Government Services Canada, 1999), 2. Medical Services Branch, *Health Programs Transfer Handbook* (Ottawa: Minster of Public Works and Government Services Canada, 1989), 7-11; .Medical Services Brach, *Pathways to First Nation Control: Final Report of Project and Strategic Planning Exercise* (Ottawa: Health Canada Publishers, 1995), 7-10; Lee Morrison and David Fish, "Unlocking the Medicine Chest: The Implications of Transferring Control of Health Services to First Nations" in *The Economic Impact of the Aboriginal Title Settlements in BC* (Vancouver: The Laurier Institute Publishers, 1997), 103 and 105-106.

[225] Health Canada, *Policy Agenda with the AFN,* prepared by Program Policy, Transfer Secretariat and Planning Directorate Medical Services Branch (March 2000), [http://www.hcsc.gc.ca/msb/pptsp /afn_e.htm].

strategies have been developed to assist First Nations communities in managing health care: transfer agreements, single funding agreements, self-government, integrated agreements and contribution agreements. Each one of these methodologies varies in the degree of responsibilities devolved to the communities and the amount of financial support received by First Nations from the government. To date, 81% of eligible First Nations and Inuit communities are involved in having resources and control over health services transferred to their communities.[226] For the remaining 19%, FNIHB continues to deliver services directly, which provides Aboriginal peoples little opportunity to partake in the policy-making process and delivery of services. In the project of self-government, health care policy and the delivery of services is primarily focused on community activities and initiatives and does not seek to replicate those services offered by other levels of government.[227] Throughout the negotiations, however, women's voices and a focus on gendered health determinants have been conspicuously absent.

The absence of women's representation in the policy-design and project of self-government illustrates the manner in which the diffusion of patriarchal ideologies has been successful in convincing male-dominated Aboriginal organizations of the benefits involved with androcentric governing philosophies. The two umbrella organizations that represent the interests of Aboriginal and Métis women are constantly finding themselves in opposition with their federally funded male counterparts. The Native Women's Association (NWAC) and Women of the Métis Nation together, represent approximately 120,000 status, non-status and Métis women across Canada.[228] In the

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[226] Medical Services Branch, *First Nations and Inuit Control 1999-2000* (Ottawa: Minster of Public Works and Government Services Canada, 1999), 2.

[227] A good example of such a program occurred in 1998 when the government announced one of the most aggressive initiatives ever taken by the Canadian state to address the legacy of the residential school experience. The state established a $350 million healing fund that would be under the administrative control of Aboriginal people and was created to fund initiatives for Métis, Inuit and First Nations people who were physically and sexually abused in Residential Schools. The money was specifically earmarked for community-based healing initiatives and has since provided funding for numerous programs focused on cultural forms of Aboriginal healing. See: Aboriginal Healing Foundation, *Background Information* (Ottawa: Aboriginal Healing Foundation, 2000), [http://www.ahf.ca/english/background.html].

[228] Jo-Anne Fiske, "The Womb is to the Nation as the Heart is to the Body" in *Feminism, Political Economy & the State: Contested Terrain*, Pat Armstrong, and M. Patricia Connelly, eds. (Toronto: Canadian Scholars Press, 1999), 293.

past, "Aboriginal women have been urged to identify as Aboriginal, in the context of domination and exploitation by the newcomer community, to the exclusion of identification as women with women across culture, and with the experience of exploitation and domination by men within Aboriginal communities."[229] The AFN has adopted a policy of promoting women's roles in the community through the use of a "traditional motherhood ideology" in which Aboriginal women are valued for their reproductive capacities, their domestic skills and other cultural gender roles.[230] In contrast, the political mandate of the NWAC is to "promote Aboriginal women's interests, including their assumptions of active role within their communities," incorporating the involvement of Aboriginal women in decision-making processes, leadership roles and embracing women as valuable participants in all aspects of community life.[231]

Aboriginal women's inclusion in the decision-making processes that fundamentally impact their lives is rare, and is reflected in the manner in which governments manufacture policy and deliver services. Women's under-representation in positions of power is further entrenched by "some Aboriginal leaders [who] believe that it is a sign of advancement not to have women involved in political discussions because, after all, that is the lesson they have learned by observing how the Canadian state operates."[232] In essence, the male stream Aboriginal organizations refuse to recognize the formidable yoke of oppression that characterizes the life situation of many Aboriginal women, and as such, stand in solidarity with the Canadian state on denying women's equality and disallowing their equal participation as full citizens. While this continued sexism and oppression is evident in various fashions, this chapter explores

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[229] Joyce Green, "Constitutionalising the Patriarchy: Aboriginal Women and Aboriginal Government" in Constitutional *Forum*, no. 4. (1993), 111.

[230] Fiske, "The Womb is to the Nation as the Heart is to the Body," 294.

[231] Lilianne Ernestine Krosenbrink-Gelissen, "The Native Women's Association of Canada," 307.

[232] Mary Ellen Turpel-Lafond, "Patriarchy and Paternalism: The Legacy of the Canadian State for First Nations Women" in *Women and the Canadian State*, Caroline Andrew and Sandra Rogers, eds. (Ottawa: University of Ottawa, 1997), 70.

how women's exclusion from the production of health care services and the implementation of policy serves to further entrench inequalities and marginalize Aboriginal women politically, socially and economically.

One of the many recommendations made by the Royal Commission on Aboriginal Peoples concerning women suggested that, "Aboriginal governments and organizations provide for the full and fair participation of Aboriginal women in the governing bodies of all Aboriginal health and healing institutions."[233] Similarly, the federal government has made a number of promises concerning the manner in which a gendered lens would be adopted in the production of public policy, as it is "intrinsic to quality policy analysis." In March 2000 the Medical Services Branch, in cooperation with the Assembly of First Nations, outlined a policy agenda for the future development and implementation of health services in Aboriginal communities. Twenty main objectives were outlined including increased access to decision-making processes, the facilitation of greater of greater control for Aboriginal peoples in the delivery of health care services, the establishment of an Aboriginal health institute, and increased funding. In this agenda women were mentioned once in the policy initiatives within the context of improving prenatal health care. Gender, however, was not viewed as a determinant of health nor was it given any specific attention.[234]

In January of 2000, the Medical Service Branch prepared a handbook on evaluating health care service "for First Nations communities that are taking control of their own health programs under the department's Health Transfer Initiative."[235] While the handbook does mention women, it is within the context of reproductive capacities reckoning back once again to the traditional motherhood ideology – women as biology. The Handbook does not however, question the manner in which programs and projects

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[233] Royal Commission on Aboriginal Peoples, *Perspective and Realties:* Volume 4 (Ottawa: Minister of Supply and Service, 1993), c.2, s.4.2.2.

[234] Health Canada, *Policy Agenda with the AFN* prepared by Program Policy, Transfer Secretariat and Planning Directorate Medical Services Branch (March 2000), [http://www.hcsc .gc.ca/msb/pptsp /afn_e.htm].

[235] Medical Services Branch, *A Handbook for First Nations in Evaluating Health Programs* (Ottawa: Health Canada, 2000), 1.

shapes women's lives, nor does is identify any services that address women's needs specifically.

The larger point here is that while the government recognizes women's lack of social, economic and political power, the rhetoric surrounding any form of commitment to gender based analysis is just that, rhetoric. The factors that affect an individual's health and well-being whether these are socio-economic, emotional or cultural have to be calculated into the formula that manufactures public policy. Charter guarantees of women's equality are irrelevant when women are struggling to simply survive. A government working in cooperation with federally funded male-dominated Aboriginal organizations has proved impotent in addressing the health care needs of Aboriginal women. While connections are being made between the health of First Nations populations and poor housing, poverty, and environmental factors, little exploration is made into what extent these factors specifically affect women and in what ways. The next section of this thesis will explore how these topics influence women's lives specifically, and the manner in which each issue can be linked to health problems that are gender specific.

Health is multifaceted, with a plethora of factors contributing to an individual's well-being. In order to understand Aboriginal women's health, one needs to first examine Aboriginal women's life situations. Research in this area is limited and in many case studies have focuses on a single band or community, which makes generalizations difficult, and in some cases impossible. There are however, certain common dominators and indictors, which may be applied at the macro level. More importantly, a microanalysis of the heterogeneous nature of Aboriginal women's health speaks to the necessity of malleable health care policies and services. This section of the project will explore several factors that contribute to the health and well-being of Aboriginal peoples and illustrate the manner in which these factors are directly related to gender.

Poverty is endemic in Aboriginal communities. Poverty is especially prevalent among single female parents, considering that seventy percent of Aboriginal families are living below the poverty line and of that seventy percent over one-half are lone-

parent households headed by women.[236] Women's lack of financial resources leads to over-crowded houses, which are often not equipped with running water and central heating. Current research suggests that seventy-five percent of on-reserve dwellings fail to meet basic Canadian standards for safe and decent living conditions.[237] These conditions affect health in a number of ways. First, poor housing conditions and over-crowding accelerate the occurrence of infectious diseases. Poor health is further intensified by lack of food security, stemming from inadequate financial resources. Contaminated water supplies and inadequate sewage treatment also contribute to the occurrence of illness in Aboriginal communities.[238] As Aboriginal women are more vulnerable to poverty than Aboriginal men, gender becomes a key element in determining how poverty influences the overall health and well-being of Aboriginal women.

Environmental factors also play an important role in shaping the health of Aboriginal communities. One of the most prominent problems arises from the toxic contaminants that are dumped into the rivers and lakes that First Nations communities rely upon as sources of water and for fishing.[239] While the AFN, in cooperation with the federal government, has established the EAGLE program (Effects on Aboriginal People from Great Lakes Environment), there is a tremendous gap in the research concerning how environmental factors affect Aboriginal women.[240] Through a process of extrapolation, however, several links may be assumed. In Canada the number of reported cases of cancers is rising due to environmental toxins. Such is the case with breast cancer as was suggested by the 1992 Greenpeace report, *Breast Cancer and the*

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[236] Martha L. Weber, *She Stands Alone: A Review of the Recent Literature on Women and Social Support* (Winnipeg: Prairie Women's Health: Centre of Excellence, 1998), 27.

[237] James S. Friederes with Lilianne Ernestine Krosenbrink-Gelissen, *Aboriginal Peoples in Canada: Contemporary Conflicts,* 169.

[238] Health Canada, *Disease Prevention and Control*, [http://www.hc-sc.gc.ca/msb/ fnihp /prev _ e.htm] 1998.

[239] Marjorie Johnson Williams and Colleen Nadjiwon Johnson, "Minobimaatisiiwin – We Are To Care For Her" in *Sweeping the Earth: Women Taking Action for a Healthy Planet*" Miriam Wyman, ed. (Charlottetown: Gynergy Books, 1999), 251.

[240] Health Canada, *Environmental Health and Related Research,* [http://www.hc-sc.gc.ca /msb /fnihp/eagle_e.htm], 1998.

Environment: the Chlorine Connection, which provided conclusive data that the "worldwide increase in breast cancer has occurred during the same period in which the global environment has become contaminated with industrial synthetic chemicals."[241] According to evidence provided by feminist researchers, women are most susceptible to ill health due to chemical contamination. Women's bodies tend to house chemicals linked to cancer (in their blood serum, body fat, breast milk, umbilical chords, placentas, and the substance that encompasses human eggs), and the poor are more likely to reside near toxic waste and contaminated chemical refuse.[242] Those women following a traditional native life style, are much more susceptible to environmental contaminants, often exposed to heavy material deposits from the fish and water, adversely effecting the content of breast milk.[243] In addition, the number of reported cases of breast cancer and cervical cancer has risen dramatically in the past forty years.[244] Aboriginal women are disproportionately over-represented in the cases of death due to cervical cancer, which is preventable in ninety percent of the cases with regular pap smears.[245] The impact of environmental toxins is often exacerbated by isolation in remote communities, which prevents Aboriginal women from appropriate preventive measures such as cancer screening and mammograms.[246] Ecological factors thus affect Aboriginal women differently then Aboriginal men and must be calculated into the formula that determines 'health.'

The final topic I would like to explore in this section is how stereotypes of Aboriginal women affect women's relations with the medical establishment. A research

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[241] Quote taken from: Megan Williams, "Breast Cancer and the Environment" in *Canadian Women's Studies*, vol.14, no.3 (Summer 1994), 7.

[242] Sandra Steingraber, "Stopping Cancer Before it Starts" in *Sweeping the Earth: Women Taking Action for a Healthy Planet*, Miriam Wyman, ed. (Charlottetown: Gynergy, 1999), 58-59.

[243] Harriet L MacMillan, Angus B. MacMillain, David R. Offord and Jennifer L Dingle, "Aboriginal Health" *Canadian Medical Association Journal*, vol. 155, no, 11 (December 1, 1996), 1572.

[244] Health Canada, *Women and Cancer: Fact Sheet* (Ottawa: Health Canada, 1999).

[245] Health Canada, *The Healing of Aboriginal Women: Fact Sheet* (Ottawa: Health Canada, 1999).

[246] Health Canada, *Community Based Programs*, [http://www.hc-sc.gc.ca/msb/fnihp/women_e96.htm], 1998.

study conducted by Annette Browne, Jo-Anne Fiske and Geraldine Thomas found that Aboriginal women's encounters with the mainstream health care system in British Columbia are fraught with negative experiences, which "revealed that these encounters influenced not only the health and well-being of First Nations women, but also the health of their families and communities."[247] The nature of Aboriginal women's encounters with the medical establishment varied from experiences of dismissal to a complete disregard of personal circumstances. Their marginalization from the medical establishment also led to feelings of vulnerability, and as such, Aboriginal women were less likely to form lasting relationships with doctors and were less likely to inform health care providers of personal life situations that directly impacted their health. Feelings of vulnerability arising from residential school experiences resulted in reluctance of Aboriginal women seeking "health care encounters involving bodily exposure in order to avoid feeling invalidated or shamed."[248] Negative stereotypes of Aboriginal women and the ensuing racism and sexism that arises from these typecasts, depicts Aboriginal women as poor mothers, sexually deviant, lazy and dirty.[249] When juxtaposed these factors result in a general distrust of mainstream medical institutions that are insensitive to the cultural values of Aboriginal peoples. Once again, Aboriginal women's encounters with the medical establishment differ from the experiences of men, in that Aboriginal women have different health concerns and are often inquiring about services for their families.

The barriers facing Aboriginal women's realization of their full health potential cannot be recognized without the use of gender-based analysis. Despite the commitment on the part of the federal government, Health Canada and the MSB, a gender-based approach is not currently being employed, nor is gender viewed as a key determinant of health. Colonialism and patriarchy have both acted to marginalize Aboriginal women's participation from decision-making process and their involvement in the creation of

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[247] Annette Browne, Jo-Anne Fiske and Geraldine Thomas, *First Nations Women's Encountered with the Mainstream Health Care Services and Systems*, 5.

[248] Ibid., 19.

[249] Kim Anderson, *A Recognition of Being: Reconstructing Native Womanhood* (Toronto: Second Story Press, 2000), 100-105.

policy that affects their lives. Incorporating gender as a key determinant of health only begins to address the complex nexus of factors that dictate the health and well-being of Aboriginal women. Other determinants include age, ability, participation in the labour market, sexual orientation and class. While recognizing that gender is a primary determinant to health and consistently employing a gendered lens acts as a good start in addressing Aboriginal women's health concerns and alienation from the medical establishment, it is only a beginning. The heterogonous culture and traditions of First Nations women, their geographical diversity, and their differential access to services requires a policy agenda which is malleable enough to address specific needs but rigid enough to demand gender, race and other such health determinants be added into the policy production formula.

IV. Praxis: Behind Door Number Three

Women's access into the realm of public policy and decision-making remains an indispensable tool for the success of the Canadian women's movement. While the state is clearly structured by patriarchal authority, there remains a great deal of discursive space in which women may contest the traditional assumptions and methodologies employed by policy architects and political actors. As Sandra Burt suggests: "public policy helps to shape the discourse of social interaction. The laws enacted by legislators in part reflect the value, or ideology, of the lawmakers. In turn these laws affect the fabric of society, imposing new limits on and possibilities for thought and action."[250] Similarly Janine Brodie maintains that public policies "are not remote from women but, instead, help shape out life chances our most intimate relationships, what we believe to be political, who we think we are, and how we make claims on the state and for what."[251] In other words, state initiated policies are intimately connected to women's empowerment and dictate a variety of outcomes for women's lives and health. Although the women's movement has tended to foreground reproductive health, I would suggest that the current state configuration and the evolution of hyper-technology

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[250] Sandra Burt, "The Changing Patterns of Public Policy," 212.

[251] Janine Brodie, "Canadian Women, Changing State Forms, and Public Policy," 13.

have spawned a myriad of new arenas of activism at both the grassroots and academic levels. Women's inclusion in the policy-making domain has increasingly being posited as important in arresting the developments of a neo-patriarchal state.

In this chapter I have argued that health care policy that fails to take gender into account is fundamentally flawed and serves to marginalize women's concerns and realties. While the federal government has publicly committed to providing appropriate gender-based analysis in the development of all state programs, the arena of public policy remained permeated with the patriarchal signature. While various debates swirl around women's involvements in the policy arena, I suggest that women's access to this traditional male bastion of power is paramount to the feminist project. Although I drew a general picture of the effects of public policy on women's situation, it should be accompanied with a caveat that significant regional and cultural differences do exist. Suffice to say, this project is concentrating on policy at the federal levels, which does impact Canadian women in a fairly uniform manner. My intent with exploring the health situation of Aboriginal women was to highlight several of these differentiations and illustrate the disparate fashions in which women experience the health care system and its associated services and programs. The differences should not however, result in activism paralysis, but rather underline the necessity of policy that is malleable to the life situation of various Canadian women.

The struggle for women's empowerment has been a long and arduous battle and has always involved the contestation of patriarchal policy and the inclusion of women's voices in the decision-making process. Navigating the current political landscape will require a feminist praxis that opposes the androcentric policy agenda and challenges state structures that maintain male privilege. The goals and challenges that have traditionally united women in challenging the basis of a patriarchal state have changed little in the past one hundred years. The women's movement was and remains a collectivity of beliefs that are predicated on achieving women's empowerment. Although the agenda of the movement has required regular adjustments and alterations to face new challenges, there remains the core principle of women's equality. In the current phase of restructuring, contesting the contemporary formulation of public policy is inexorably linked to women's enjoyment of their full health potential. While policy

design and implementation is certainly not the only avenue of activism, is does serves as a major weigh point on the map towards women's empowerment.

Chapter Four

Opportunity Knocks: The Health Care Crisis in Canada

We do not see out teas, herbal medicines, oils, massage, compresses, poultices, salves, social support, willingness to listen, counsel, offers of emotional support, and our empowerment of each other as activities that have no value. When women do them for each other and for children, and of course for the men we know, they are neither productive nor reproductive. Men seldom have these skills or undertake these tasks except when paid to reinforce a patriarchal ideology – as priest, as hospital social worker, as police officer. They have all the comfort and support they need from institutions that reinforce their power and gender, which ensure an enslaved comfort should their system fail them.

– *Marilyn Waring* [252]

Introduction

Medicare is Canada's most cherished and popular social program. Symbolically, it stands as a fundamental distinction between Canada and the United States. Politically, it illustrates the Canadian public's willingness to direct government actions aimed as achieving a collective good enjoyed by all Canadians. Our sacred cow of universal, accessible, portable and comprehensive health care, however, is popularly considered to be in a state of crisis.[253] The culprit of the health care crisis is typically identified as a fiscal problem arising from the escalating price of high-tech medical equipment, the aging population, cuts in federal spending, high labour costs, and a general lack of overall efficiency. In other words, proponents of deficit monster arguments maintain that the health care crisis is a crisis of affordability and the system must therefore necessarily be downsized, restructured and, according to some neoliberal supporters, privatized. The push to undermine the current health care model's core tenets of universality and accessibility and replace these with effectiveness and

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[252] Marilyn Waring, *Counting for Nothing: What Men Value and What Women Are Worth*, 2nd ed. (Toronto: University of Toronto Press, 1999), 173-174.

[253] Miriam Smith, "Retrenching the Sacred Trust: Medicare and Canadian Federalism" in *New Trends In Canadian Federalism*, François and Miriam Smith, eds. (Ontario: Broadview Press, 1995), 319.

efficiency has been a perennial theme in the various provincial commissions on health care and will inevitably permeate the recently established national commission. Despite the breach in social contract the federal government continues to claim that it is upholding its responsibilities under the Canadian Health Act (CHA).

In Canada, the CHA, introduced by Parliament in 1984, has served as the foundation of the Canadian health system, outlining the federal commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The primary objective of "Canadian health care policy is to protect, promote and restore the physical, mental well-being of residents of Canada and to facilitate reasonable access to health care without financial or other barriers."[254] While the CHA defines particular stipulations and criteria that the provinces must fulfill to qualify for full fiscal transfers, it does not regulate provincial health care programs and services. Although the current Prime Minister, Jean Chrétein, presents himself as "a protector of Medicare" and the defender of the 'average' citizen, the Canadian health care system is in a shambles.[255] Shortages of nurses and doctors, closures of hospitals, delisting of services, lack of beds, long waiting lists, health facilitators' strikes and privatization are all among the most commonly cited indicators of the Canadian health care crisis. The potential for a sustainable and manageable health care system that provides Canadian citizens with health entitlement rights is portrayed as folklore of Canada's past.

The federal government has however, recently offered Canadians an opportunity to participate in the future of the Canadian health care system through the establishment of a Royal Commission. Royal Commissions, focused on policy initiatives, carry considerable potential for widening the scope of democracy and empowering individual citizens and organizations by including their voices in the decision-making process. Jane Jenson describes royal commissions as "core institutions of representations for Canadian politics" which hold considerable potential for innovations in the field of

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[254] Canada, *Canadian Health Act* (Ottawa: Government of Canada, 1984), c.6, s.3.

[255] Desmond Morton, "What Has He Really Done Wrong" in *Policy Options*, vol.21, no.9. (November 2000), 8.

public policy.[256] As Neil Bradford describes, "federal royal commissions enjoy a degree of autonomy in the world of ideas that create exceptional opportunities for driving policy change."[257] The Canadian health care system and by extension women's heath, will indubitably be shaped by the recently mandated Royal Commission on the Future of Health Care in Canada (RCFH), and therefore the women's movement's participation is fundamental to the future of women's health in Canada.

When the Prime Minster announced the launch of the RCHC on April 4, 2001 federal health care minister Allan Rock suggested, "the First Minister's agreement on funding and a Health Actions Plan [would] serve as a blueprint to meet the short and medium term challenges facing our health care system."[258] However, eight days later, the final report of the Saskatchewan Commission on Health was tabled, with Mr. Rock commending the sole commissioner Ken Fyke on his recommendations, advocating the use of the report for the national commission and suggesting that the Saskatchewan report would "provide valuable insight to the pan-Canadian review and dialogue on health care."[259] Although the government is claiming that the Agreement of the First Ministers on health care will act as the primary framework for the RCHC, I believe that the final report of the Fyke commission promises to have a profound impact in shaping the contours of the national report.[260] The degree of influence the Saskatchewan

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[256] Jane Jenson, "Commissioning Ideas: Representation and Royal Commissions" in *How Ottawa Spends 1994-95: Making Changes,* Susan D. Phillips, ed. (Ottawa: Carleton University Press, 1994), 59.

[257] Neil Bradford, "Innovation By Commission: Policy Paradigms and the Canadian Political System" in *Canadian Politics,* 3rd ed. James Bickerton and Alain-g Gagnon, eds. (Ontario: Broadview Press, 1999), 548.

[258] Interestingly, the minister of health cited "changing demographics" (an aging population) and the "rising cost of technologies and treatments" as the two primary challenges facing the health care system. See: Prime Minster's Office, *Prime Minister Announces Commission on the Future of Health Care in Canada* (Ottawa, Ontario: Government of Canada, April 4, 2001), [http://pm.gc.ca/newsroom].

[259] Health Canada, *Health Minister Welcomes Fyke Commission Report* (Ottawa: Health Canada, April 12, 2001), [http://hc-sc.gc/English/archives/releases/2001/2001_38e.htm].

[260] In September of 2000, the First Ministers agreed on a health agenda that would "preserve, protect and improve the health of Canadians." Seven specific commitments were made to strengthening and renewing the Canadian health care system. 1. support the principles of universality, accessibility, comprehensiveness, portability and public administration for insured hospital and medical services; 2. continue to renew health care services by working with other governments, communities, service providers, and Canadians; 3.promote those public services, programs and policies which extend beyond

commission will have on the federal commission is further expounded by the appointment of the former Saskatchewan premier Roy Romanow, who established the provincial commission and appointed Kenneth Fyke. [261] I am thus proposing that the SHCC will serve as an early indication of the focus and processes that will direct the national project. Thus while the royal commission promises to provide feminist scholars and women-centered organizations a variety of political prospects for public dialogue and participation into the decision-making realm, the primacy of the new public management approach to policy design and increasing militancy of the neoliberal agenda, all evident in the SCCH, should alert feminists to the degree of vigilance that will be necessary on the part of the women's movement during its involvement with the RCHC.

In this chapter I explore the processes of the Saskatchewan Commission and discuss several of the recommendations of the Fyke report. Through an analysis of the Saskatchewan Commission I hope to flesh out problems that the women's movement will face in their participation in the national commission and recommend several strategies designed to encourage women's participation and ensure a feminist analysis in the future design and implementation of Canadian health care policy. To begin, I briefly trace the trajectory of health care policy in Saskatchewan and discuss the policy

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care and treatment and which make a critical contribution to the health and wellness of Canadians; 4. further address key priorities for health care renewal and support innovations to meet the current and emerging needs of Canadians; 5. expand the sharing of information on best practices and thereby contribute to continuing improvements in the quality and efficiency of their health care services; 6. report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services, and the actions taken to improve these services; and, 7. work in collaboration with Aboriginal people, their organizations and governments, to improve their health and well being. Through their commitment to these principles the Minister developed an "Action Plan," in which they outlined the agenda for the future of Canadian health as being premised on access to care, health promotion and wellness, appropriate health care services, primary health care, an appropriate supply of doctors, nurses and other health personnel, home care and community care, pharmaceuticals management, health information and communications technology, and health equipment and infrastructure. The meeting and the subsequent agenda for the future of health care produced little in the way of an alternative vision for addressing the current health care crisis. Health Canada, First Ministers' Meeting (Ottawa, Ontario - September 11, 2000) http://www.scics.gc.ca/cinfo00/800038004_e.html; *Health Canada, 2000-2001 Estimates Part III – Report on Plans and Priorities* (Ottawa: Health Canada, 2001).

[261] Although, Quebec recently tabled the Clair Commission on health care in that province, little has been mentioned by the federal government concerning the finding in the RCHC. See Québec, *Commission d'étude sur les services de santé et less services sociaux: Emerging Solutions – Report and Recommendations* (Québec: Gouvernement du Québec, 2001).

agenda that has dictated the delivery of the province's health care services. Second, I outline the core recommendations advocated by the Fyke Commission and explore the process used to arrive at these proposals. Finally, I explore several strategic methods that could be employed by the women's movement and advocates of women's full health potential during the public consultations on the RCHC. My primary objective in this chapter is to identify necessary avenues of activism and highlight those issues that merit particular attention from both feminist scholars and the women's movement.

The Golden Boys and the Golden Calf

Discourses surrounding the health care system in Canada are dominated by a lexis suggesting that the good ship health care is sinking. The affordability crisis of health care indicates that the system will not survive another five years unless it is completely restructured, and maintains high levels of efficiency and effectiveness. Although the health care system that was established during the reign of the welfare state, which was primarily concerned with universal access to care, is still recognizable, the vision is fading quickly. Fortunately, the sheer popularity and public support of Canada's health care system has left governments in quite a quandary. On the one hand, health care is a hot political topic, leading to both the provincial and federal levels of government claiming to be the proprietors and defenders of health services. On the other hand, health care is the most expensive social program in Canada, establishing it as a primary target for cost containment and reform. Even though the current status of the health care system in Canada has been profoundly impacted by the shrinking role of the state and neoliberal economic philosophy, health care remains a priority to most Canadian citizens.

Effectiveness and efficiency are two of the most commonly used buzz words to describe the reforms necessary to maintain the health care system. Obviously, all Canadians agree that our health care system should be effective, providing citizens with optimum services, and that the system should be efficient, not creating waste or gratuitous expense. However, the fashion in which politicians and economic actors are using the discourses of efficiency and effectiveness are not tantamount to conventional

meanings of these terms. As Mike Burke describes, the politics of efficiency from a policy perspective "is no longer about producing a desired outcome using the least costly mix of resources, but about diluting or abandoning certain outcomes in order to reduce costs."[262] Similarly, effectiveness arguments based on accountability and the optimum use of health resources also borrow their strategic design from the business sector. The effectiveness paradigm supports such measures as user-fees, privatization and a decreased labour market. Medical practices are dictated by evidence-based decision-making, which operates on the assumption that "what matters in health care is what can be counted, measured or determined through rationalized trials. Management science is united with medical science to allow greater control over providers and patients alike."[263] Health care is thus analyzed through a hybrid approach of effectiveness and accountability, which seeks to concretely manage and economically censor the abstract and multifaceted dimensions of the health care needs of Canadian citizens.

Proponents of the neoliberal agenda believe that the efficiency and effectiveness of health care services may be maximized through the adoption of total quality management (TQM), which is a managerial strategy based on high quality service, low cost solutions and full profit exploitation. One of the central tenets of the TQM approach is "the notion of continuous quality improvement" which comes from "focusing on processes rather than outcomes."[264] TQM is a stratagem typically employed by corporations that wish to attract more customers and become more competitive within the market. Within the context of health care TQM falls within the ambit of new public management, as the state seeks to decrease the government's role in the public domain by adopting private sector practices. In theory, new public management seeks to deal with "large and expensive public sectors . . . getting the debt

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[262] Mike Burke, "Efficiency and the Erosion of Health Care in Canada" in *Restructuring and Resistance: Canadian Public Policy in an Age of Global Capitalism*, Mike Burke, Colin Mooers, and John Shields, eds. (Halifax: Fernwood Publishing, 2000), 180.

[263] Pat Armstrong, Hugh Armstrong, Ivy Bourgeault, Jacqueline Choinier, Eric White and Jerry P. White, *Health Thyself: Managing Health Care Reform* (Toronto: Garmond Press, 2000), 31.

[264] Pat Armstrong and Hugh Armstrong, *Wasting Away*, 122.

problems under control . . . the rapid development of information technology . . . people demanding better services and knowledge" and the empowerment of employees through innovations.[265] Proponents of TQM view this managerial strategy as an ideal neoliberal remedy that provides "the palliative certainty of an in-house 'cure' that skillfully avoids addressing the larger ills inherent to capitalist economies."[266]

While this new style of public management is currently being adopted by hospitals right across Canada, TQM and its attendant goals of effectiveness and efficiency have little relevance to managing the health of Canadian citizens. Both structurally and ideologically the arguments in support of this new mode of health care administration are deeply flawed. Structurally, TQM views hospitals and other health services as competitive entities attempting to attract consumers. Canadian hospitals are not, however, competing for clients, nor are they or should they be competing amongst themselves. Second, efficiency arguments are only applicable if there is a reduction in overall spending with a containment of quality. Such is certainly not the case as public expenditures on health care have decreased by 13% overall in the last ten years, while the private health care industry has rapidly expanded with Canadian citizens experiencing a 20% increase in the outflow of personal resources.[267] Ideologically, TQM views citizens as consumers of health services and translates health into a marketable commodity. Viewed through this lens, TQM detracts from social citizenship (not to mention common citizenship) removing health care as an entitlement of citizenship. While the federal state curtails its spending power, the provincial governments truncate their role in health care, which provides the private sector advocates the logic for the establishment of a two-tiered or privatized system.[268]

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[265] Quoted in Donald Savoie, "The Civil Service" in *Canadian Politics,* 3rd ed., James Bickerton and Alain-G Gagnon, eds. (Ontario: Broadview Press, 1999), 158.

[266] Joel Davison Harden, "Making the Links: Neoliberalism, Medicare and Local Control in an Age of Globalization" in *Citizens or Consumers? Social Policy in a Market Society,* Dave Broad and Wayne Antony, eds. (Halifax: Fernwood Publishing, 1999), 181.

[267] Andrew Jackson and David Robinson, with Bob Baldwin and Cindy Wiggins. *Falling Behind: The State of Working Canada, 2000* (Ottawa: Canadian Centre for Policy Alternatives, 2000), 144.

[268] As Evan et al suggests, the arguments used to justify TQM and privatization is premised on extremely shaky logic. For instance the Alberta government's proposal "for meeting unmet needs,

The situation of Canadian nurses serves as a clear illustration of just how egregious the TQM approach is to health care. There are approximately 230,000 working nurses in Canada today, 98.6 percent of who are female.[269] In fact, 80 percent of all individuals employed in the field of health care are women.[270] The effectiveness and efficiency paradigm promotes an internecine model of health care that pits nurses against nurses in competition for jobs, and nurses against patients who expect nightingale-type care. TQM has altered the very nature of nursing-care as nurses are increasingly expected to adopt "a 'for productivity' rather than a 'for care' orientation" when treating patients.[271] TQM stipulates precisely, for instance, the length of time it should take to give a patient a bath or assist a patient with a meal. High levels of acuity also decrease the human component of the nursing profession, as patients are processed through the system as quickly a possible. This reconfiguration of health care has fundamentally altered traditional nursing responsibilities, shifting the focus away from their original roles as primary care-givers who addressed the entire dimension of health care (mental, spiritual, emotional and physical).[272] Finally, the pressures emanating from the TQM approach forces health workers to discharge patients earlier, contributing to the use of home care and private nursing care, both of which are non-insured services. There are thus several gendered dimensions embed within the health care crisis that must be addressed in the upcoming RCHC. For the most part, women's

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expanding service capacity to deal with shortages and waiting lists . . . is at best seriously incomplete. Alberta cut provincial spending by 30% between 1992 and 1995. The 1999 level was still 15% below that of 1992, over that seven years, Alberta's per capita hospital expenditures fell from 6% above the Canadian average to 6% below. To reduce public hospital expenditures and then turn around and argue for the need for private hospitals or facilities to meet shortages of capacity seems disingenuous at best." See: Robert Evans, Morris L. Barer, Steven Lewis, Michael Rachlis and Greg L. Stoodart, *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare*? (British Columbia: Centre for Health Services and Policy Research, 2000), 1.

[269] Mark Nichols, "At the Breaking Point" in *Maclean's* (January 8, 2001), 24.

[270] Pat Armstrong and Hugh Armstrong, *Wasting Away*, 100.

[271] Jerry White, "Changing Labour Process and the Nursing Crisis in Canadian Hospitals" in *Feminism and Political Economy: Contested Terrain*, Pat Armstrong and M. Patricia Connelly, eds. (Toronto: Canadian Scholars' Press, 1999), 63.

[272] For a historical overview of nursing in Canada and traditional nursing roles see Dianne Dodd and Deborah Gorham, eds., *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Ottawa: University of Ottawa Press, 1994).

situated experiences in the context of health care were virtually ignored by the SCHC. Thus, at this juncture I would like to turn to an examination of the Fyke Commission to determine which avenues of activism must be explored in the future to encourage women's full health potential and associated empowerment.

Saskatchewan has, more often then not, been considered a 'have-not' province, with a largely rural population base and an economy predominately predicated on agriculture. Nonetheless, Saskatchewan was the birthplace of Medicare and continues to sustain, however erroneously, a reputation for championing accessible, universal health care policy and programs. While the strategic direction of the Saskatchewan health care system was not defined until the mid-sixties, piece-meal municipal programs have been providing the residents of Saskatchewan with publicly accessible health care services since 1914. The vagaries of an always-volatile agricultural market encouraged the often geographically disparate agrarian communities to establish local health care facilities, shielding citizens from the uncertainties of the farm economy. Typically, a number of small municipalities would combine their financial resources, garnered from municipal taxation, to establish a union hospital that provided medical services to the surrounding districts.[273] By the time the government of Tommy Douglas introduced legislation that provided Saskatchewan residents with comprehensive Medicare, an extensive system of health care facilities already existed. Since the entrenchment of the provincial Health Care Act, the health care system has been considered the jewel of the province's history.

Jurisdictional power for the provinces to direct health care policy flows from section 92(7) of the *BNA Act*, which provide the provinces with exclusive authority to enact legislation concerning health care. Federal influence in the area of health care has always stemmed from its spending power, which has allowed Ottawa to impose and enforce national standards without infringing on those constitutional powers relegated to the provinces. However, as the federal government's level of spending steadily declines, so too does its ability to impose uniform policy and national standards of

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[273] Dale Eisler, "In The Beginning," Special Report of Saskatchewan Health Care: Diagnosis Anxiety, *Regina Leader Post,* 30 November 1996, 5.

health care.[274] As Robert Evans highlights, "the role of the federal government is now critical to the future of the system yet its policy has been surprisingly ambiguous."[275] While both the federal and provincial orders of government must possess the political will to sustain and improve upon the core elements of the CHA (universality, accessibility, comprehensiveness, public administration and portability), Ottawa's declining cash contributions has motivated some provinces to explore new mechanisms for delivering health care by transferring budgetary cost to the private sector.[276] Stanch supporters of privatization, such as physicians, pharmaceutical companies and private insurers are pushing provincial governments to open up health care services to competitive markets, whereas nurses, the women's movement, progressive social organizations, and a number of Canadian citizens are demanding that the federal government treat health care as a right owed to all Canadians regardless of wealth, geographic location, race, gender or age.[277]

The Fyke Commission reflects both of these views, examining how health care is organized and funded, in addition to investigating the 'wellness' of Saskatchewan communities. Today, Saskatchewan health care is barely recognizable from the original vision of Tommy Douglas, early crusader of a universal health care system and pioneer of the policy program that eventually evolved into the Canadian health care system.[278] In the early 1990s the provincial government embarked on a comprehensive reform of

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[274] Miriam Smith, "Retrenching the Sacred Trust: Medicare and Canadian Federalism" in *New Trends In Canadian Federalism*, François and Miriam Smith, eds. (Ontario: Broadview Press, 1999), 321.

[275] Robert G. Evan, "Canada" in *Journal of Health Politics, Policy and Law*, vol.25, no.5 (October 2000), 895.

[276] In 1999 the federal government in conjunction with the provinces introduced the Federal Health Accord, which has allocated an additional $2 billion for health care in each of the next two fiscal years. In addition, the federal government has promised to supplement health care cost over the next three years with an extra $2.5 billion. Despite government claims that these cash injections will be a short-term panacea to the health care crisis, these tokenized payments are only an anaemic attempt to appease public unrest concerning health care as federal transfers still remain fall below the pre-CHST levels. Andrew Jackson and David Robinson, with Bob Baldwin and Cindy Wiggins, *Falling Behind*, 147.

[277] Robert G. Evan, "Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform" in *Journal of Health Politics, Policy and Law*, vol.22, no.2 (April 1997), generally.

[278] See: Thomas H. McLeod and Ian McLeod, *Tommy Douglas: The Road to Jerusalem* (Edmonton: Hurtig publishers, 1987).

the Saskatchewan health care system, closing over fifty rural hospitals, slashing the health care budget by $53 million, abolishing the universal drug plan and delisting a variety of services.[279] The Wellness Model, as it was called, focused on two primary ideas: "health services should contribute to wellness, not just treat illness" and "communities [should] be empowered to plan and deliver integrated health services to meet local needs."[280] Health care minister Louise Simard and deputy minister Duane Adams embarked on a number of programs designed to establish a health care system that addressed all aspects of an individual's health and preserve well-being through a holistic approach.[281] Simard even addressed gender inequalities and took measures to ensure resources focused on women's full health potential. Nonetheless, the loss of federal funds, the skyrocketing costs of technical equipment, the nursing deficit and the flight of practitioners to the more lucrative American markets have all served to severely erode the province's ability to sustain the health care system Saskatchewan was renowned for. As Tom McIntosh describes it, the final report of the Fyke Commission seeks to revolutionize the very culture of Medicare and the manner in which citizen understand their health care system, by extending various components of the wellness model through the development of primary care 'working teams' and the attenuation of regional hospitals. [282]

The Commission on the future of Saskatchewan health care was established in June of 2000 and tabled its final report in April 2001. The Commission was given a tripartite mandate: 1) "identify key challenges facing the people of Saskatchewan in reforming and improving Medicare," 2) to recommend an action plan for the delivery of health service across Saskatchewan through a model that is sustainable and embodies the core values of Medicare" and 3) "to investigate and make recommendations to

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[279] Howard Leeson, "Health Care Reform in Saskatchewan" in *Management,* vol.6, no.4 (Fall 1995), 12.

[280] Ibid.

[281] Duane Adams, "The Future and Long-Range Planning of Healthcare Services: A Saskatchewan Perspective" in *World Hospitals,* vol.30, no.1 (Fall 1993), 25-31.

[282] Tom McIntosh, *A Fyke in the Road: The 'New' Politics of Health Reform* (Regina: Saskatchewan Institute of Public Policy, 2001), 1.

ensure long-term stewardship of a publicly funded, publicly administered Medicare system."[283] In early October, the Commission released *Caring for Medicare the Challenges Ahead,* which detailed the focus and breadth of the Commission's agenda.[284] Following the release of this report, public dialogue was conducted through "two television forums on the provincial SCN network that involved approximately 500 health care providers and 200 members of the public from throughout the province."[285] In addition, the Commission disturbed a questionnaire titled *Caring for Medicare: Thinking About the Challenges Ahead,* which received 33,000 responses from Saskatchewan residents.[286] While the report accepted 200 submissions from private individuals, unions, professional medical groups and health advocacy organizations, the Commission's report is predominantly void of any discussion on the social function of the health system. In addition, women are mentioned only twice in the report, both instances occurring within the context of reproductive health.[287]

Indicative of the neoliberal agenda, the final report's main concern is with efficiency and effectiveness, calling for the closure of approximately 20 rural hospitals, the conversion of 30 hospitals into community care centers, the amalgamation of 32 regional health boards into 9 or 11, and the establishment of five tertiary hospitals in Regina and Saskatoon. The Commission promotes a population health approach and recommends that the majority of future research be conducted using an evidence-based model.[288] Finally, the Commission argues that the implementation of Fyke's plan would

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[283] Saskatchewan Commission on Medicare, *Caring for Medicare: Sustaining A Quality System* (Regina: Government of Saskatchewan, 2001), 86.

[284] Saskatchewan Commission on Medicare, *Caring for Medicare: The Challenge Ahead* (Regina: Government of Saskatchewan, 2000).

[285] John L. Hylton, *Saskatchewan's Commission on Medicare: An Analysis of Finding and Implications,* unpublished paper (June 2001).

[286] Saskatchewan Commission on Medicare, *Caring for Medicare,* 5.

[287] Ibid., 13 and 35.

[288] Ibid., 7 and 39

reduce government expenditures by 30%-35%, but it does not mention how it the plan will reduce deaths or improve on the health of Saskatchewan people.[289]

As John Hylton punctuates, "the Commission believes that concerns about quality should override concerns about access," a point which speaks to the deterioration of the core principles of the CHA, as one principle is given predominance over another, rather than developing a system that sustains an equilibrium.[290] The most important factor of the Fyke Commission, for the purposes of this project, is the lack of involvement on the part of women's groups and the complete absence of feminist analysis. The Commission did not make a formal call for proposals, nor did it seek out the advice of health advocacy groups other than experts that reside outside of the province.[291] Indeed the driving element behind the final report appears to be bureaucracy and not citizenship input.[292] While there are significant gaps in the coverage of the report and there is generally a lack of public input, the Commission does reject privatization of health care services. Nonetheless, the report is premised on a neoliberal agenda, excluding women's voices and removing the sense of empowerment all citizens should have the opportunity to garner from such an undertaking. The Saskatchewan Commission does offer feminist scholars and activists of the women's movement with an opportunity to critique the process of the report and create strategies to ensure women's participation in the forums on the National Commission. At this point I would like to explore several areas that I believe are paramount to women's full health potential and must therefore be addressed and integrated into the analysis and recommendations of the federal commission.

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[289] Ibid., 81.

[290] John L. Hylton, *Saskatchewan's Commission on Medicare,* 4.

[291] Ibid., 2.

[292] For instance, the Canadian Mental health Associations submitted an extensive report detailing many of the challenges facing individuals with mental illness and offering remedies to overcome the alienation and impact that deinstitutionalization has had on those suffering from psychological illness. While the CMHA's report was mentioned in the commission's final report, its recommendations were not addressed, nor were the affects of deinstitutionalization on mental health patients dealt with. Canadian Mental Health Association, *Making Connections Happen: A Progress Report on Saskatchewan's Mental Health System* (Regina: Canadian Mental Health Association, 2001).

Opportunity Knocks

An individual's health potential can be directly correlated to their economic status, education, position in the labour market and housing conditions.[293] Poverty, age, literacy, gender, race, ethnicity, ability and geographic location are all prominent factors in determining the type of health care an individual will require and their accessibility to these services. The coalescence of hyper-technology, neoliberalism and neoconservatism has served to severely dilute the state's commitment to ensuring the well-being of the population. During a recent CBC interview concerning the massive federal spending cuts to the health care system Jean Chrétein was quoted as saying that Canadians would have to accept "a no-frills public Medicare system from now on," which he understood as reasonable considering the idea that "nobody loses his [sic] home because someone has a problem with his teeth or his eyes."[294] The Prime Minister's statement is revealing on a number of levels. First, it is of course, gender specific. Second, he is suggesting that the Canadian health care system did or does cover the cost of dentistry and optometry, which it does not. Third, Chrétein is arguing that health care should not be understood as an entitlement of citizenship, but rather a luxury that the Canadian state can no longer afford.

The neoliberal agenda, the biomedical model, the medicalization of women's bodies and neoconservatism all continue to support a health care system that is inherently oppressive and market driven. Policy engineers have increasingly adopted the biomedical view, championing it as an objective model upon which health services can be predicated. Further exacerbating the situation is the neoliberal economic policy supporting privatization and demanding that spending be curtailed on the extensive health care system in Canada. So where is the women's movement to begin in addressing this nexus of patriarchy, capitalism and hyper-technology and how are we to ensure that the RCHC will promote women's full health potential?

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[293]Monica Townson, *Health and Wealth*, generally.

[294] Quoted in Colleen Fuller, *Caring for Profit*, 83.

The first issue the women's movement needs to tackle is the health care agenda being propagated by proponents of neoliberal economic policy. Political elites and economic actors are continually arguing that the public expenditures concerning the delivery of health care are no longer manageable, and as such, current levels of care must be restrained. The introduction of the Canadian Health and Social Transfer program, the 'phasing out' of numerous health care positions, and the transfer of health care to the community are all directly associated with the neoliberal argument. This economic agenda has become increasingly justified by a particular understanding of what constitutes 'appropriate' levels of health care. While the rhetoric concerning a budgetary crisis in the health care sector is erroneous, it does allow political actors to shift the public's attention away from the true culprits undermining the Canadian health care system. Although the government claims that health care costs are escalating exponentially, other data suggests that the cost of the health care system has stabilized in the last decade and that "spending on health remains considerably below what [it was] prior to 1992."[295] The affordability crisis is not a crisis caused by rampant spending on Medicare and other health services, but rather the result of special status for pharmaceutical companies, privatization, and the fee-for-service system. In accordance with the Trade-Related Aspects of Intellectual Property Rights and the introduction of Bill C-22, the federal government regularly grants "special status to the brand-name pharmaceutical firms protecting them from competition."[296] With the health care system obliged to purchase these higher costing drugs, cutbacks to other services and the loss of jobs ensue. Another factor affecting the public purse is the fee-for-service system by which most Canadian doctors are paid.[297] The system pays practitioners for every service performed, which can be viewed as an incentive for doctors to order expensive tests and recommend costly treatments.[298]

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[295] Mike Burke, "Efficiency and the Erosion of Health Care in Canada," 178.

[296] Pat and Hugh Armstrong with Claudia Fegan, M.D., *Universal Healthcare: What the United States Can Learn from the Canadian Experience* (New York: The New Press, 1998), 134.

[297] The fee-for-service is not a universal aspect of the Canadian healthcare system as both Saskatchewan and Ontario have salaried doctors.

[298] Pat and Hugh Armstrong with Claudia Fegan, M.D., *Universal Healthcare: What the United States Can Learn from the Canadian Experience.* 136.

The second factor the women's movement must focus on stems from the federal government's inertia on the actions of some provinces to privatize, and hospitals to contract out for services that are no longer available due to the downsizing of the health care's labour force. Not only does privatization lead to inequality within the health care system, the American expenditures on privatize health care services serve as an explicit example of the danger associated with this choice. In the United States health care expenditures represent 12 percent of the Gross Domestic Product and denies millions of Americans access to health care.[299] In Canada, in contrast, health care accounts for only 7.3 percent of the GDP and provides universal coverage for all citizens.[300] Therefore, one of the top priorities concerning health that the women's movement must address is the government's retreating role from its commitment to a national universal standard of health care. Feminists need to continually interrogate the discourses surrounding downsizing, restructuring and monetary accountability in order to contest the manner in which the delivery of health care service is being framed.

The biomedical model's support of a system of 'evidence-based medicine,' should also be a primary focus of the women's movement. Evidence-based medicine is a "medical practice based on data and assessment of whether producers or treatments are of benefit for their intended purpose."[301] Traditionally, clinical medicine treated patients and adapted procedures on a case-to-case basis. However, patient care with evidence-based medicine is developed through "the use of standardized evaluation procedures such as clinical trials that generate aggregate data . . . to inscribe biomedical knowledge on clinical practice."[302] Feminist techno-science critics view evidence-based medicine as a dangerous enterprise, as it is closely linked with insurance companies and

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[299] Colleen Fuller, *Caring for Profit: How Corporations are Taking Over Canada's Health Care System* (Ottawa: the Canadian Center for Policy Alternatives, 1998), 119.

[300] Pat Armstrong, Hugh Armstrong, Jacqueline Chioniere, Eric Mykhalovskiy and Jerry P. White, *Medical Alert: New Work Organizations in Health Care* (Toronto: Garmond Press, 1997), 16.

[301] Lorna Weir and Jasmin Habib, "A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies" in *Studies in Political Economy*, vol.52 (Spring 1997), 141.

[302] Ibid., 143.

is indicative of an epidemiological transition. When population levels stabilize, the demographic transition is linked to an epidemiological transition in which "a sustained decline in morbidity and mortality rates [is] accompanied by a major alteration in disease patterns."[303] To control the economic impacts of this transition, evidence-based medicine relies on information from massive health care databases where the safety and efficiency of specific treatments are evaluated based on medical research and experimentation. Health insurance companies are beginning to adopt claim criteria based on a system where the only medical procedures recognized as valid are those that are premised on this form of research. This is in contrast to the old system, which allowed health "providers discretion about individual case treatment, patient privacy, and patient involvement in treatment decisions."[304]

Flexibility in the delivery of treatment is paramount to women's full health potential as it allows practitioners to treat patients on an individual basis by focusing on their personal life situation. In addition, the evidence-based approach promotes surveillance medicine, which studies women as a single category without taking into account race, class, sexual orientation, age, ablism and so forth.[305] The biomedical model and the research methodology behind it, therefore, perpetuate the assumption that an allopathic approach to medicine, which suggests that illness arises primarily from biological factors, is the only viable mechanism through which to deliver health care.[306] The women's movement thus needs to challenge these assumptions and illustrate that the core conjectures of this model are market driven and not motivated to sustain and improve public health.

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[303] Jane Stein, *Empowerment & Women's Health,* 85.

[304] Adele E. Clarke and Virginia L. Olesen, "Revising, Diffracting, Acting," 23.

[305] Ibid., 22.

[306] David Alan Long and Terry Fox describe an allopathic approach to healthcare as "[T]he tendency of western practitioners and policy-makers to fragment and dehumanize the healing process. They do so by viewing health as the absence of physical disease, by awarding the status of expert to westernized health-care practitioners, and by focusing most policies and programs on alleviating the symptoms of health problems rather that their underlying causes": See: David Alan Long and Terry Fox, "Circles of Healing: Illness, Healing, and Health Among Aboriginal People in Canada" in *Visions of the Heart: Canadian Aboriginal Issues*, David Alan Long and Olive Patricia Dickason, eds. (Toronto: Harcourt Brace and Company Publishers, 1998), 240.

Another problem inherent in the reorganization of the health care system in Canada is the shifting of primary health services into communities and homes. During the national commission advocates of women's health must be especially vigilant in addressing this topic and demonstrating the negative impacts this type of arrangement may have on both the individuals requiring care and the caregiver.[307] This reorganization of care is intended to decrease the stress on the medical system and is said to improve the recovery time of patients. By suggesting that deinstitutionalization will both empower patients in the decision-making process and improve the delivery of health services, the government has set about 'policy changes by stealth.'[308] The move to deinstitutionalize has translated into the loss of thousands of beds for the mentally ill, the elderly and the disabled. In addition, hospital stays following surgery or serious illness have been shortened dramatically, with patients being sent home to receive care from family and friends.[309] While these measures are concerned with cost cutting and not health care, they are also steeped in neoconservative ideology. The shift from institutional care to care located in the private sphere has a far greater impact on women who are disproportionately responsible for providing the care. In the home, women are expected to care for the young, the elderly and the disabled, which in turn impacts the health of the women providing the care and their ability to seek paid labour. In the institutions, volunteerism is expected to replace the loss of professional nursing staff

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[307] See: Janet Fast, Jacquie Ealse and Norah Keating, *Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors* (Ottawa: Status of Women Canada, 2001),

[308] Changing public policy by stealth refers to a process by which "changes to policy are made without a genuine process of public consultation or debate and are done through technical measures announced in budgets. The political reasons for stealth, from a government perspective, relates to the challenge of cutting social benefits in the face of growing economic insecurity and substantial public opposition." See: Michael J. Prince, "From Health and Welfare to Stealth and Farewell: Federal Social Policy, 1980-2000" in *How Ottawa Spends 1999-2000: Shape Shifting: Canadian Governance Toward the 21st Century*, Leslie A. Pal, ed. (Toronto: Oxford University Press, 1999), 158.

[309] Pat Armstrong, "Unraveling the Safety Net: Transformations in Health Care and Their Impact on Women" in *Women and Canadian Public Policy,* Janine Brodie, ed. (Toronto: Harcourt Brace & Company, Canada, 1996), 137.

and as the group of volunteers donating their labour is predominately comprised of women, there is again a strong dependence on women's unpaid labour.[310]

Rescuing the Sacred Cow

Deficit crisis, restructuring and downsizing were indicative of the 1990s governing philosophy in Canada and were a primary justification for health reform. The political landscape in Canada has changed dramatically however, as the new millennium ushered in a period of federal fiscal surplus.[311] The post-deficit era has not however witnessed an alteration in the governing paradigm emblematic of the nineties, nor has the course of health care reform been altered to resuscitate the post-war system of publicly managed and funded services. Neoliberalism, neoconservativism and technological advancements continue to dominate political discourse and dictate state agendas. The federal government continues to abdicate its responsibilities down to the provinces, many of which are unable or unwilling to burden the large expenditures associated with the maintenance of the Medicare system.

The absence of women's voices in the Fyke Commission should alert women's groups to the necessity for solidarity and organized action. The Canadian women's movement and feminist scholars must actively participate in shaping the future of Canada's health care system and promote women's empowerment through a redirection of policy and services concerning health care. As Rohan Maharaji maintains:

> The women's movement has as its theoretical underpinnings: the political nature of the personal experiences, egalitarianism in relationships, and the nurturing and validation of women's experiences. A direct extension of these principles is the empowerment of women in all aspects of their life including health care and ownership of health knowledge. This empowerment and ownership has led to revolutionary approaches in health care policy and delivery, in terms of recognizing and advocating for patient autonomy, respect for the patient's rights, mutuality in the decision making process and a more client-centered approach to medical care.[312]

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[310] Pat Armstrong, Hugh Armstrong, Jacqueline Chioniere, Gina Feldberg and Jerry P. White, *Take Care: Warning Signals for Canada's Health System* (Toronto: Garmond Press, 1994), 47.

[311] Leslie A. Pal, "Balancing Act: The Post-Deficit Mandate" in *How Ottawa Spends 1998-99 Balancing Act: The Post Deficit Mandate*, Leslie A. Pal, ed. (Toronto: Oxford University Press, 1998), 1-30.

[312] Rohan Maharaji, "The Role of Women's Advocacy Groups in Shaping Canadian Health Care Policy" in *Women's Health Issues,* vol.9, no.5 (September/October 1999), 259.

Pat Armstrong offers both feminist scholars and the women's movement an excellent location from which to begin our analysis, activism and participation in the upcoming RCHC. Armstrong argues that health should be understood as "a social issues and a social contract rather than simply medical and technical problems to be addressed by experts."[313] Further, she maintains that women will continue to "struggle over both access to resources and access to the right to define health" and that while "women often lose these struggles, they remain continually active in shaping their own health."[314] Feminist praxis provides the women's movement with the necessary tools to achieve women's empowerment and promote women's full health potential and the RCHC provides the impetus for change. Women's successes stemming from the RCSW and the commission on violence against women serve as fundamental examples of how we as scholars, we as activists and we as women can participate in the direction of our future. We can challenge the assumptions being propagated by neoliberal ideologues that health is a commodity that can be bought and sold on the open market and we can achieve empowerment through our collective identity and our individual experiences.

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[313] Pat Armstrong, "Women and Health: Challenges and Changes" in *Feminist Issues: Race, Class and Sexuality*. 2nd ed. Nancy Mandell, ed. (Scarborough: Prentice Hall Allyn and Bacon Canada, 1998.), 249.

[314] Ibid., 250.

Conclusion

Towards Women's Empowerment: Walking Through The Door

Feminist ideology should not encourage (as sexism has done) women to believe they are powerless. It should clarify for women the power they exercise daily and show them ways this power can be used to resist sexist domination and exploitation

- *bell hook*[315]

Throughout history, women's empowerment has been impaired by a social contract that privileges male experience over female experience. Feminists refer to this male advantage as patriarchy and have identified its presence in every aspect of social, economic and political life. Religion, the state, the family, the economy, and society have all provided men greater access to resources, a superior presence in the decision-making process and a greater sense of empowerment over their own lives. And just as all other aspects of our culture and society have evolved and grown over time, the authority and power of patriarchy have advanced; in essence, a new form of patriarchy has risen from the ashes of the post-welfare state. Contemporary politics and its attendant discourses are a veritable jungle of patriarchal influence and control. The trilogy of neoliberalism, hyper-technology and neoconservatism operate in concert to advance the modern manifestation of male privilege, seeking to entrench the neo-patriarchy into the cultural fabric of our imminent post-millennium future. Neo-patriarchy, accompanied by his henchmen - advanced capitalism and social conservatism - seek to perpetrate women's subordinate status in the future through the valorization of technological knowledge, a contracting public arena and an increasing endorsement of self-realized health, happiness and success. To understand how neo-patriarchy operates as an active ideological force, I contend that feminism must be cognizant of the primary components on which the contemporary manifestation of male privilege is established.

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[315] bell hooks, *Feminist Theory: From Margin to Center* (Boston: South End Press, 1984), 12.

The first core component of neo-patriarchy that I identified was hyper-technology. I argued that while hyper-technology is a recently new addition to male privilege, is quickly gaining status as the prodigal son of the patriarchal family. I labeled contemporary technology as hyper, suggesting that it is ubiquitous, erratic, and often unconscionable, which I substantiated by exploring the affect hyper-technology has on women's health, lives and potential for empowerment. I discussed various feminist theoretical perspectives and addressed both theoretical and practical literature in order to gain an understanding of the relevant concepts and issues women face in the context of technological authority in the new world order. If Jonathon King and Doreen Srabinsky's conjectures are accurate and we are entering the first stage of the technical revolution, there should be a concerted effort on the part of feminist scholars to continue interrogating the project of hyper-technology. I suggested that the extension of feminist analysis and scholarship on this topic is paramount to the agenda of the women's movement and must be used to accentuate how hyper-technology is the linchpin in the neo-patriarchal agenda. Although I used NRTs as a practical example of the importance of feminist theories concerning technology, various other areas should be further expanded to determine how hyper-technology is affecting women's life situations. For instance, the use and production of genetically modified food or foods that contain genetically engineered organisms has recently incited international debate, stemming from health concerns, environmental ramifications, and the corporate control of the food industry.[316] In order to fully comprehend hyper-technology in terms of politics, we must be aware of what mediates the relationship between hyper-technology and the user, who benefits/profits from the development and dissemination and who it harms. The expansion of feminist frameworks and critiques that consider the affects of hyper-technology must be expedited, as the trajectory of hyper-technology is increasingly accelerated. The rise of global techno-economic integration, the advancements in medical science, the momentum of the biotech industry and the onslaught of computer technology and communication devices are all developments

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[316] See: Deborah Barndt, ed. Women Working the NAFTA Food Chain: Women, Food and Globalization, (Toronto: Second Story Press, 1999); Carole M. Counihan, ed. The Anthology of Food and Body: Gender, Meaning and Power (New York: Routledge, 1999); Mariarosa Dalla Costa, "Some Notes on Neoliberalism, on Land and The Food Question" in Canadian Women's Studies, vol.17, no.2 (Spring 1997), 28.

which signal the necessity of feminist's theories and activism focused on hyper-technology and its impact on women. In the context of women's health, neoliberalism and neoconservatism stand as the bookends of women's oppression with hyper-technology acting as the shelf upon which women are placed. Therefore feminist scholars must cultivate a critical approach to unmask the deeply embed patriarchal assumptions associated with the biomedical model. Further, feminist scholarship must carefully police the relationships between scientific research and commercial interests

The second and third components of neo-patriarchy I identified were neoliberalism and neoconservatism. In order to fully understand how contemporary state forms and governing philosophies affect women's health and associated empowerment, I examined women's citizenship status. I argued that women's empowerment in relation to health is directly predicated on their ability to partake in the Canadian polity as full citizens. The process of empowerment begins "with women's participation in the design of research, policy and programming."[317] There are however, four major impediments to women's full health potential. First, there are the various discourses of misogyny that serve to advance a patriarchal agenda through phallocentrism, androcentrism, and sexism. Second, women's health is fundamentally impacted by the valorization of new technologies and the biomedical model. Third, the ascendancy of neoliberalism has served to marginalize women's participation and undermine the potency of the women's movement. Finally, neoconservatism, operating in tandem with neoliberalism, has rerouted health care responsibilities into the private sphere. To address the synergistic affects of hyper-technology, neoliberalism, neoconservatism and the discourses of misogyny requires feminists to employ both theoretical tools and women-centered activism. In other words, a feminist praxis that unites feminist scholarship and the women's movement promises to promote solidarity without undermining the situated experiences of a multiplicity of women and lead women down the path of empowerment.

I proposed two questions as the beginning of this thesis: what key theoretical tenets would provide the necessary impetus for women's empowerment and its

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[317] Margaret Denton,Maroussia Hadjukowski-Ahmed, Mary O'Connor and Isik Urla Zeytinglu, *Women's Voices In Health Promotion* (Toronto: Canadian Scholars Press, 1999), 17.

relationship to health? And how are policy entrepreneurs impairing or improving women's health status? Policy entrepreneurs have a direct impact on the lives and full health potential of Canadian women. The failure to view gender as a key determinant in health care analysis is a fundamental flaw in the current process used to develop policy. Guided by the gender-neutral language of neoliberalism, health care policies are premised on the population approach, which minimizes women's situated health concerns and extrapolates data that fails to capture the full context of women's lives. Thus the use of the population approach in the context of women's health is instrumental in impairing women's full health potential and associated empowerment. Employing a gendered lens would serve to correct the biased results produced from such a methodology; however, the federal government's commitment to such analysis has been undermined by its failure to provide the necessary financial resources to women-centered departments and provincial healthcare boards. In addition, the women's movement's ability to contest the production of public policy has been sharply curtailed by its loss of state funding in the recent past. Under the aegis of neoliberalism, the current citizenship regime further exacerbates the situation by reconfiguring what constitutes a good citizen. Globalization, consumerism, hyper-technology and a myriad of economic and political factors operate in concert to displace women's concerns in the name of advanced capitalism and efficiency.

In order to arrest these insidious developments the women's movement and feminist scholars must develop a new feminist praxis. The central theme throughout this project has been the ability of feminist scholars to provide the women's movement with practical theories that direct feminist praxis and demonstrate the manner in which neo-patriarchy impairs women's empowerment and promotes the voracious clutch of capitalism that in turn undermines women's full citizenship status. The goal of feminism and the women's movement has always been empowerment. We have fought to empower women through the vote, through bodily autonomy, through independence both financial and social, and through education. As Monique Deveaux suggests "feminist writing on empowerment suggests the need to place the subject's interpretations and mediations of her experiences at the center of our inquires into the

how and whys of power."[318] Empowerment must thus act as both a place to begin and goal to be accomplished, as an antidote to male privilege and an elixir of female liberation.

Although there is substantial common ground to which the women's movement and feminist scholars attest, there are also challenges each face independently. Women-centered activists must prevent political impasses associated with identity politics, while continuing to contest state and medical practices that seek to undermine women's agency. In contrast, feminist scholars must exemplify the type of political philosophy that delineates theoretical frameworks capable of informing women-centered activism by translating abstract theoretical conjectures into concrete practical applications. Both components are equally important for developing a feminist praxis that empowers women and seeks to expose the multiple forms of oppression women experience. While feminist scholars must overcome discrimination from within the academy, women-centered activists must struggle to overcome discrimination they face on the public political stage.[319] The women's movement has been a powerful source of transformation in Canadian society and will continue to act as a prevailing vehicle for political, economic and social change. The effects of feminist activism have produced an extensive shift in the consciousness of the Canadian people in the past and still have the potential to do so in the future. However, the successes of the contemporary women's movement will be predicated on locating a common feminist praxis, which incorporates a variety of contrasting ideological currents and a symbiosis between theory and practical application.

A system of women's health care is not evident in the Canadian system, and thus is it necessary to emphasize the multiple dimensions of health as opposed to the linear approach propagated by the medical establishment. The failure to establish programs for women's health care has alienated women from the process, fostering a cultural of male medicine. The growth of hyper-technology, neoliberalism and

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[318] Monique Deveaux, "Feminism and Empowerment," 233.

[319] See for instance VèVè Clark, Shirley Nelson Garner, Margaret Higonnet, and Ketu H. Katrak, *Anti-Feminism in the Academy* (New York: Routledge, 1996); Christine Overall, *A Feminist I: Reflection for Academia* (Ontario: Broadview Press, 1998).

neoconservatism, which all find support from politicians, economic actors, and the mainstream media, are so persuasive and our society so indoctrinated by their rhetoric, the inevitability of state downsizing has become incontrovertible. The government's exiguous attempts to incorporate women into the policy-making agenda have produced a policy environment that neither encourages women's participation nor promotes alternative agendas that support women's full health potential. According to Jean Barr and Lynda Birke, women's empowerment in the context of health is profoundly impaired when "women are disenfranchised by the construction of scientific knowledge," leaving women's health caged in male conceptualizations.[320] Instead of addressing this topic, the government's dance card is full with questions concerning whether or not our Medicare system should provide an equable, universal healthcare system or provide a profit.

Throughout this thesis I have identified the women's movement as the primary vehicle available to women to contest the contemporary hegemonic paradigm and to challenge mainstream conceptualizations of health. Although the women's movement's relationship to the state is intrinsically laced with the current inclination of political actors and the media to label the movement as a 'special interest' group, feminist theories of the state continue to require the analytic attention of both academics and activists alike. Janine Brodie describes the paradox of our current situation:

> Although the political economy of the new order marks an intensification of gender, restructuring discourse denies its political significance. The rhetoric around market-driven adjustment is both dehumanized and degendered. Similarly, the discourse around the deficit and erosion of the welfare state obscures the unequal gendered impacts of this so-call "belt-tightening" episode in Canadian political development. In turn, the women's movement has lost its privileged position as the representative of the collective interests of women in the welfare state. Instead, it is being recast as just another special interest group whose claims for state intervention are both self-interested and oppositional to the collective interest.[321]

Neo-patriarchy, is not however beyond contestation and the current period of state restructuring affords the women's movement with an important opportunity to argue that universal health care is a feminist priority, and reflects women's expression of desire for freedom from oppressive technologies and elitist medical practices. The

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[320] Jean Barr and Lynda Birke, *Common Science?*, 19.

[321] Janine Brodie, "Restructuring and the Politics of Marginalization" in *Women and Political Representation in Canada* (Ottawa: University of Ottawa Press, 1998), 34.

success of the World March of Women, which has recently been nominated for the Nobel Peace Prize, illustrates the power of our collective voices. [322] A feminist praxis is our Rosetta stone for deciphering the modern state and communicating effectively our demands and goals. Through the development and application of a feminist praxis, academics and activists may foster their own empowerment and transform unjust political institutions, challenge the erosion of women's citizenship and the associated rights, and emphasize the multi-faceted issues facing women within their situated context. Although the intellectual currents of feminism constitute a kaleidoscopic body of philosophy, it is able to delineate theoretical frameworks capable of informing women-centered activism and transforming theory to praxis. Therefore out of the cornucopia of feminist praxis, a wealth of political actions will tumble allowing the establishment and evolution of a movement committed to a paradigmatic shift that empowers women and promotes their full health potential in mind, body and spirit.

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[322] World March of Women 2000, "2000 Good Reasons to March" in *Newsletter*, vol.4, no.1 (February 2001), 16.

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